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IMJ

Illinois Medical Journal

Official Journal of the Illinois State Medical Society

Volume 174, Number 1, July 1988

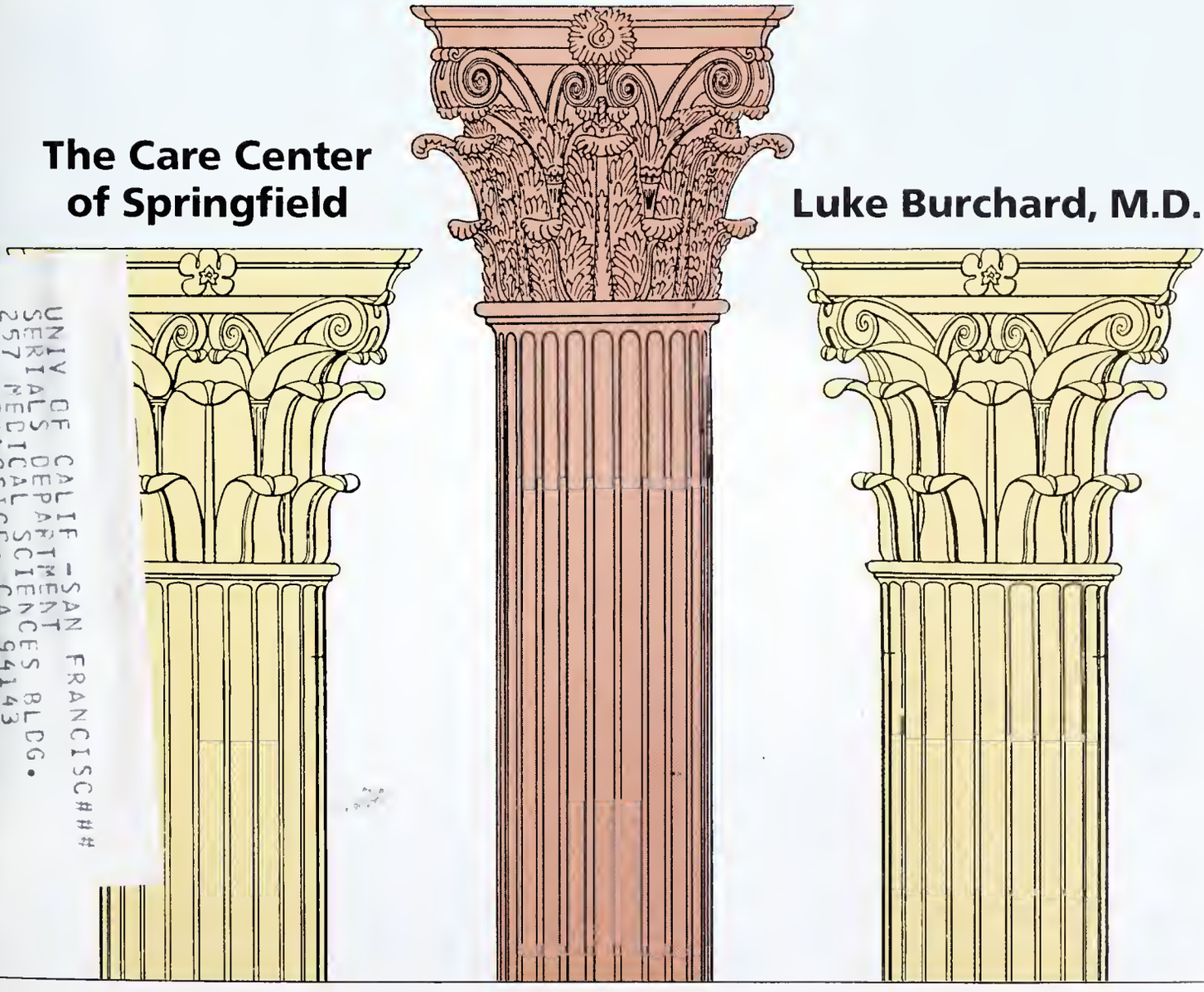
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1988 ISMS Public Service Awards

The Care Center of Springfield

Luke Burchard, M.D.



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REPORT FOR Illinois Physicians

AIDS

GENERAL BLUE CROSS POLICY

Serologic testing is employed to detect antibodies to the AIDS virus, which is currently identified by the term "Human Immunodeficiency Virus (HIV)". The virus originally was named "Human T-cell Lymphotropic Virus, Type III (HTLV-III)", a term that remains in common usage.

Antibodies may be detected by a variety of immunoassay techniques, the most common being an enzyme linked immunosorbent assay (ELISA). When an assay is reactive on initial testing, it should be repeated on the same specimen. A more specific test, (Western blot, immunofluorescent assay) is usually performed following repeatedly reactive ELISA results.

The tests may be covered when performed to help determine a diagnosis for symptomatic patients. They are not covered when furnished as part of a screening program for asymptomatic persons.

AIDS COORDINATOR

Blue Cross and Blue Shield of Illinois' AIDS coordinator is available to assist hospitals, physicians and members with discharge planning and to facilitate obtaining alternative benefits outside of the scope of the patient's benefit program. Assuming payment of premiums, no Blue Cross member will lose contractual benefits as a result of any such notification. Notification will enable the AIDS Coordinator to monitor patient progress and to recommend and facilitate benefit exceptions as appropriate.

The Blue Cross AIDS Coordinator is a registered nurse who can be reached at (312) 938-8141 for case management.

CLAIM CODING

ICD-9 CODES

Claims for patients manifesting symptoms of AIDS and who have had two positive ELISA and one positive Western blot should be coded 795.8 as either the primary or secondary discharge diagnosis.

Additional ICD-9 CM codes have been developed to accurately monitor diagnoses of AIDS and other manifestations of HTLV-III/LAV infection. These codes should be added to your current ICD-9-CM coding books; codes range from 042.0 thru 044.9.

The new codes are divided into three categories:

1. HTLV-III/LAV infection with specified secondary infections and malignant neoplasms (042).
2. HTLV-III/LAV infection with other specified manifestations in the absence of specified secondary infections and malignant neoplasms (043).
3. Other HTLV-III/LAV infection not classifiable above (044).

CPT-4 CODES

86312 = HTLV-III = Antibody Detection; ELISA

86314 = HTLV-III = Antibody Detection Conformatory Test (e.g., Western blot)
Two ELISA tests conducted on the same specimen must both be positive and this information must be indicated on the claim.

MEDICARE NOTES

NEW REMARKS CODES—EOMB MESSAGES

The following are *new* "Remarks" codes and explanations that now appear on Remittance Notices to providers and Explanation of Medicare Benefits to beneficiaries.

005 Submitted amount and allowed amount are the same.
006 A special method was used to set the customary charge (see item 5b on back). The number of claims processed for this service was not enough to set the charge in the usual manner.
007 A special method was used to set the prevailing charge (see item 5c on back). The number of claims processed for this service was not enough to set the charge in the usual manner.
020 Medicare does not pay for transportation in a wheelchair van.
113 Medicare does not pay for ambulatory surgical center fees on a non-assigned basis. Please ask the center to submit this claim.
114 Medicare does not pay for charges when the service is not described.
116 Medicare does not pay for services of a doctor's assistant outside of a doctor's office unless the doctor accepts assignment. (This applies to the services of a "physician's assistant" *only*).
165 Medicare does not pay for this because it is part of a total charge for the test group.
166 Medicare does not pay for laboratory procedure which have not been approved by the Food and Drug Administration.
167 When a doctor bills for a test that he bought from an outside source, payment can be made only if the doctor accepts assignment.
168 Medicare does not pay for diagnostic tests without a physician statement "No purchased services are included" *or* unless the bill shows who performed the test and the amount charged by the supplier.
182 Medicare usually does not pay for more than one visit a day. See item 1 on back.
183 Medicare usually does not pay for like services by more than one doctor of the same specialty. See item 1 on back.
184 Medicare did not pay for this service because the Peer Review Organization did not approve it.
185 Medicare does not pay for this equipment when oxygen is not being used.
190 Medicare does not pay for this because the x-ray does not prove you need it.
191 Medicare usually does not pay for such an extensive procedure. See item 1 on back.
192 Medicare usually does not pay for this many visits or treatments. See item 1 on back.
193 Medicare cannot pay for this service unless the need for it is clearly stated on the claim. See item 1 on back.
194 Medicare usually pays for only one nursing home visit per month. See item 1 on back.
195 Medicare usually does not pay for like services by more than one doctor during the same time period. See item 1 on back.
196 Medicare usually does not pay for this many services within this period of time. See item 1 on back.
197 Medicare usually does not pay for more than one visit a day. See item 1 on back.
198 Medicare usually does not pay for like services by more than one doctor of the same specialty. See item 1 on back.
199 Medicare usually does not pay for this shot. See item 1 on back.
214 A claim must be sent to your employer group plan first. After the claim has been processed by that plan, resubmit this claim with your bills and the notice the other insurance company sent you if the bill has not been paid in full.
215 A claim must be sent to your employer group plan first. After the claim has been processed by that plan, resubmit this claim with your bills and the notice the other insurance company sent you if the bill has not been paid in full.
225 The hospital should have paid for these services.
269 Medicare usually does not pay for this service. See item 1 on back.
280 The hospital has not given Medicare information needed to process this claim.
341 This service was furnished by the hospital. The bill was sent to (Part A intermediary name) for processing. You will hear from them.
355 Medicare does not pay the extra charge for deluxe frames.

372 Amount approved limited by item 5c on back. (Psychiatric)
373 Amount approved limited by item 5b on back. (Psychiatric)
374 Amount approved limited by item 5c on back. (Psychiatric)
377 Amount approved limited by item 5b on back. (Psychiatric)
378 Amount approved limited by item 5c on back. (Psychiatric)
379 Amount approved limited by item 5b on back. (Psychiatric)
382 A special method was used to set the customary charge (see item 5b on back) because not enough charge data was available. (Psychiatric)
383 A special method was used to set the prevailing charge (see item 5c on back) because not enough charge data was available. (Psychiatric)
384 A special method was used to set the customary charge (see item 5b on back) because not enough charge data was available. (Psychiatric)
385 A special method was used to set the prevailing charge (see item 5c on back) because not enough charge data was available. (Psychiatric)

(This report is a service to the physicians of Illinois)

IMJ

Illinois Medical Journal
Illinois State Medical Society

Volume 174, No. 1
July 1988

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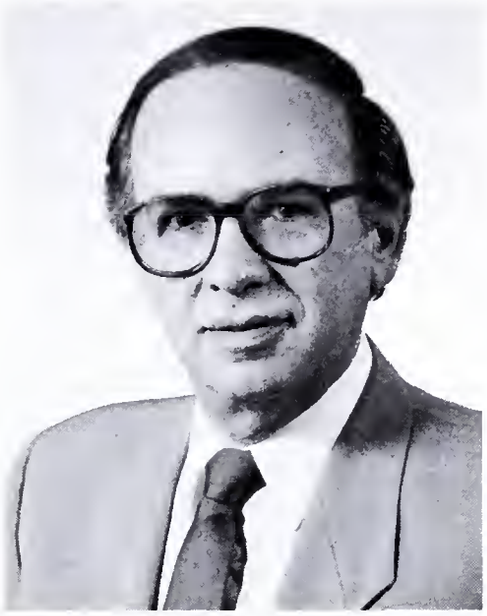
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Illinois Medicine: The Best We Can Be



The role of the professional medical association has evolved in tandem with the many social changes altering the face of today's medical practice. State medical societies were once the sole means to publish and share information about clinical advances. No general physician association can keep pace with modern clinical progress; we now join our specialty groups for that purpose. And we join our county, state and national medical societies to keep pace with shared socioeconomic concerns. The medical society gives us a mechanism to influence our collective professional environment and public health policy.

The Professional Liability Initiative and the continuing high-profile role we've taken on medical malpractice tort reform, as well as the huge public education effort on AIDS, are two ready examples of how the Society has moved into the public domain. And the overwhelming demand for a change in our communications vehicles evidenced in the 1987 all-member survey was consistent with that.

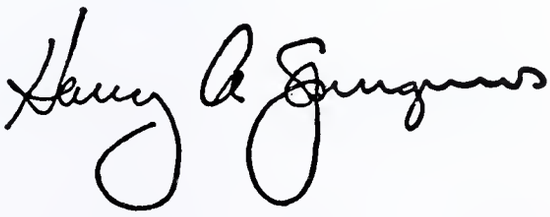
Many of you participated in the focus groups on our communications program held across the state last summer. Your comments directed the leadership to pursue an evolutionary change in our publications. The end-product of that effort will come to your offices this fall, when you receive the preview issue of our new official organ: a tabloid newspaper called *Illinois Medicine.*

Illinois Medicine will embrace all of the goals you set out for the Society in the all-member survey and focus groups. It will be a highly informative news publication in the classic tradition. We will do our best to give you what you need to know to exercise your franchise in the professional environment. *Illinois Medicine* will challenge your intellect and provoke you to a new awareness of our individual and collective potential.

Beginning in January, 1989, you will receive a single twice-monthly publication which will take the place of the myriad mailings you're accustomed to receiving from the Society. A snapshot of the Illinois health care environment with editorial comment on the Society's perspective, *Illinois Medicine* will give you everything ISMS has to offer in a readily accessible, straightforward format. The new publication will carry insurance news from the Exchange, and news on our component sections and affiliate groups. Practice management concerns will have their place, as will any topic of interest to the Illinois physician. And an increased circulation will enable us to share all of this with members of the media and the legislative community.

I hope you will read it and I hope you will share your thoughts when you do. You may not agree with the comments of our adversaries, which must be a part of the news stories if the news stories are to be complete. But you will be far better able to respond to those comments, and to present your views, when you can speak as an informed and savvy observer. And if you keep the leadership and staff aware of your feelings, through letters to the editor and comments when we meet, this publication will continue to evolve in tandem with your needs and interests.

That's the bottom line. *Illinois Medicine* will be what we make it. Let's work together to see that it's a reflection of the best that Illinois medicine can be. ◀



Harry A. Springer, M.D.
President

THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by Allen J. Malmed, M.D., department of radiology, Loyola University Medical Center, Maywood.

The patient is a 70-year-old man who has had worsening pain in his right shoulder for three months. He had received cortisone in the shoulder two months before.



Figure 1
Right humerus. There are medullary calcifications. The cortex (arrows) is abnormal. There is amorphous periosteal new bone formation.



Figure 3
Figure 3A. Magnetic resonance proton density image shows low signal in the proximal humerus. (arrow)



Figure 3B. Magnetic resonance T^2 weighted image shows high signal in proximal humerus (arrow) which contains foci of low signal.

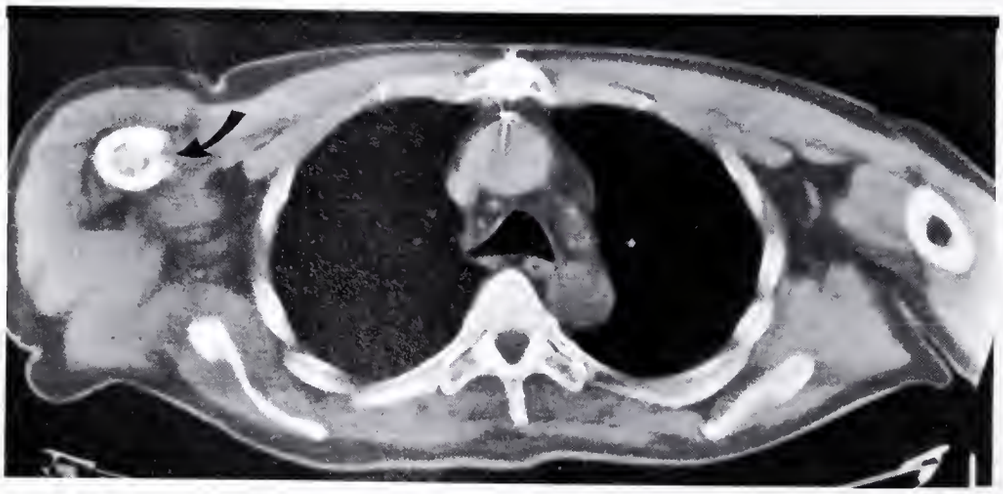


Figure 2
Computed tomography shows destruction of medial cortex of the proximal humerus. (arrow) There is intramedullary calcification.

Your diagnosis?

1. Osteomyelitis
2. Enchondroma
3. Chondrosarcoma
4. Ewing's tumor
5. Bone infarct

(Continued on page 55)



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Before prescribing, see complete prescribing information in SK&F CO. literature or PDR. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: *Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.*

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. *If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake.* ***Associated widened QRS complex or arrhythmia requires prompt additional therapy.*** *Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.*

Precautions: *The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin[ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.*

Adverse Reactions: *Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.*

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L45

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OBITUARIES

****Andelson, Mayo M.,** Chicago, died May 9, 1988, at the age of 87. Dr. Andelson was a 1924 graduate of Rush Medical College, Chicago.

***Bolotin, Joseph T.,** Chicago, died February 22, 1988, at the age of 84. Dr. Bolotin was a 1927 graduate of the University of Illinois College of Medicine, Chicago.

Boraca, Carl T., Evanston, died March 21, 1988, at the age of 41. Dr. Boraca was a 1972 graduate of Loyola University Stritch School of Medicine, Maywood.

***Brown, Hyman N.,** Skokie, died December 4, 1987, at the age of 87. Dr. Brown was a 1925 graduate of the University of Illinois College of Medicine, Chicago.

***Hall, Louis C.,** Chicago, died December 14, 1987, at the age of 79. Dr. Hall was a 1945 graduate of the University of Health Sciences/Chicago Medical School.

***Hoyne, Robert M.,** Champaign, died February 3, 1988, at the age of 72. Dr. Hoyne was a 1941 graduate of Northwestern University Medical School, Chicago.

***Jabczynski, Hilbert A.,** Calumet City, died February 20, 1988, at the age of 81. Dr. Jabczynski was a 1934 graduate of the University of Health Sciences/Chicago Medical School.

****Jones, William M.,** Chicago, died May 2, 1988, at the age of 89. Dr. Jones was a 1932 graduate of the University of Chicago Pritzker School of Medicine.

***Mallory, Joseph R.,** Mattoon, died May 2, 1988, at the age of 73. Dr. Mallory was a 1943 graduate of the Washington University School of Medicine, St. Louis.

***Newton, Michael,** Chicago, died May 24, 1988, at the age of 67. Dr. Newton was a 1943 graduate of the University of Pennsylvania School of Medicine, Philadelphia.

Pawluk, Jerry T., Chicago, died February 24, 1988, at the age of 60. Dr. Pawluk was a 1961 graduate of Medizinische Fakultat der Universitat Innsbruck, Innsbruck, Austria.

****Rosenblum, Arthur H.,** Chicago, died May 12, 1988, at the age of 79. Dr. Rosenblum was a 1935 graduate of the University of Chicago Pritzker School of Medicine.

***Schaffner, Morton J.,** Chicago, died December 27, 1987, at the age of 65. Dr. Schaffner was a 1950 graduate of the University of Health Sciences/Chicago Medical School.

***Schwartz, Harold,** Evanston, died March 20, 1988, at the age of 70. Dr. Schwartz was a 1943 graduate of the University of Colorado School of Medicine, Denver.

***Shapiro, David B.,** Des Plaines, died May 2, 1988, at the age of 43. Dr. Shapiro was a 1973 graduate of the University of Health Sciences/Chicago Medical School.

****Straus, Francis H.,** Chicago, died May 8, 1988, at the age of 93. Dr. Straus was a 1919 graduate of Harvard Medical School, Boston.

***Tarkington, Joseph A.,** Evanston, died February 1, 1988, at the age of 71. Dr. Tarkington was a 1943 graduate of the University of Cincinnati College of Medicine, Cincinnati.

****Wills, Holmes T.,** Three Oaks, Michigan, died April 28, 1988, at the age of 79. Dr. Wills was a 1938 graduate of the University of Health Sciences/Chicago Medical School.

***Worth, Theodore D.,** Chicago, died January 9, 1988, at the age of 90. Dr. Worth was a 1925 graduate of Fak der Universitat Wien, Vienna, Austria.

***Zalar, Joseph A.,** Joliet, died February 21, 1988, at the age of 80. Dr. Zalar was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*



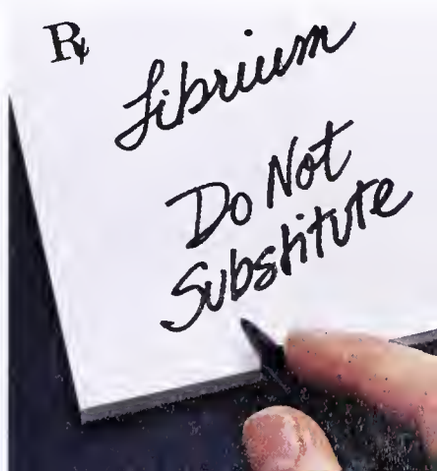
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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

The epidemiology of varicose veins was examined in the Framingham Study. Commencing with the ninth exam in 1966 and continuing until 1982, 3,822 adults aged 30-62 were studied. Of the 1,720 men and 2,102 women free of varicose veins in 1966, 396 men and 629 women developed varicose veins within the 16-year follow-up. General incidence was higher in women then men until age 80, and tended to occur in women at earlier ages. While men and women with varicose veins had a higher incidence of atherosclerotic cardiovascular disease than those without, only the excess risk of coronary heart disease in women was statistically significant. Women with varicose veins were more often obese, had lower levels of physical activities (less than four hours per day), had higher systolic blood pressures and were older at menopause. For men, varicose veins coexisted with lower levels of physical activities and a higher incidence of smoking. (Brand, F., *et al: Am J Prev Med* 4:2,96-101,1988)

The patient's severity of symptoms and his concern about these symptoms should govern decisions as to prostatic surgery. Short-term complications of varying severity occurred in 24% of patients, 4% reported continued incontinence, and 5% suffered impotence. Symptoms improved in 93% of cases with severe prostatism and in 79% with moderate prostatism. The results suggest improvement in the quality of life and emphasize the importance of patient participation in the decision to undergo a prostatectomy. (Fowler, F., *et al: JAMA* 259:20,3018-3022,1988)

Omega-3 fatty acids are being used to reduce plasma triglycerides and lipoprotein levels, reduce the thrombogenicity of platelets in the microcirculation due to effects on the production of mediators derived from arachidonic acid, alter inflammatory and immune cell function, and retard development of atherosclerosis. Epidemiologic studies have shown an association between fish consumption and reduced cardiac mortality, and between omega-3 fatty acid intake and decreased serum lipid levels and prolonged bleeding time. This study showed that non-insulin-dependent-diabetic patients with hyperlipidemia and accelerated atherogenesis taking omega-3 fatty acids showed an increase in the fasting blood glucose levels. Omega-3 fatty acid treatment in type II diabetes leads to rapid but reversible metabolic deterioration, with elevated basal hepatic glucose output and impaired insulin secretion, but unchanged glucose disposal rates. It should be recommended to type II diabetics with very great caution. (Glauber, H., *et al: Ann Int Med* 108:5,663-8,1988)

Thirteen 56-year-old hypertensive men and their normotensive control subjects were followed and evaluated with noninvasive cardiac and renal function tests for seven years. The hypertensive men had diastolic pressures of greater than 105mmHg and signs of hypertensive cardiac involvement, as judged by a prolonged left ventricular relaxation time. Seven years of antihypertensive treatments resulted in: (1) normalization of central and peripheral hemodynamic variables; (2) reversal of left ventricular hypertrophy in proportion to blood pressure control; (3) normalization of systolic wall stress and a well-preserved systolic left ventricular function; (4) normalization of diastolic left ventricular function; and (5) normalization of increased microalbuminuria and a decrease in renal vascular resistance, with no change in glomerular filtration rate compared to control subjects. Regression of cardiovascular structural changes can be achieved with long term antihypertensive treatment. (Hartford, M., *et al: JAMA* 259:17,2553-7,1988)

Postmenopausal estrogen supplementation reduces the risk for angiographically significant coronary artery disease. Clinical, laboratory, and angiographic data were abstracted from the cardiac catheterization reports of 6,452 women patients between 1972-1984. Factors other than estrogen use that would alter the incidence of coronary artery disease were excluded. Physicians utilizing estrogen treatment in postmenopausal women for osteoporosis or coronary artery disease should be apprised of the increased risks for other diseases such as endometrial cancer and gall bladder disorders. (Sullivan, J., *et al: Ann Int Med* 108:3,358-63,1988)

Decompression laminectomy and a lateral spinal fusion were performed in 62 patients who had a previously failed lumbar disk removal. Follow-up averaged 4.2 years and efficacy was based on positive response to surgery, pain relief, improved function, and return to work. Thirty-two percent felt that the procedure gave them a good result, 29% claimed a fair result, and 38% had a poor result. Factors that correlated with a higher improvement were the presence of a unilateral radicular pain, a pain-free interval of one year following surgery, and a positive myelogram for new or recurring disk herniation rather than a cicatrix formation. Those patients with industrial claims improved less, and only 14% of patients with claims returned to work, compared to 61% of patients without an industrial injury history. (Quimjian, J., Matrka, P.: *Orthopedics* 11:4,563-9,1988) ◀

Announcing a new benefit beyond price alone.

Advanced Formula

Mytrex®

(nystatin-triamcinolone acetonide)



New—fragrance-free formula

- ☐ Avoids the #1 irritant in cutaneous reactions[1]
- ☐ No methylparaben, propylparaben, or ethylenediamine
- ☐ Virtually nonsensitizing vanishing cream base

Uncompromised anticandidal effectiveness

- ☐ Faster, more thorough control of erythema and pruritus than nystatin or triamcinolone alone
- ☐ Unexcelled control of pruritus ani, candidal diaper rash, intertriginous fungal infections associated with diabetes mellitus or chronic maceration

Convenience for compliance



- ☐ b.i.d. regimen
- ☐ Both popular dosage forms—cream and ointment

...and still economical

Please see facing [following] page for brief summary of prescribing information.

Systemic absorption of topical corticosteroids has produced reversible HPA suppression manifestations of Cushing's syndrome, hyperglycemia and glucosuria in some patients. Pediatric patients may demonstrate a greater susceptibility.

Reference: 1. Adams RM, Maiback HI, Clendenning WE, et al: A five-year study of cosmetic reactions. *J Am Acad Dermatol* 1985;13(6):1062-1069.

SAVAGE LABORATORIES
a division of Altana, Inc.
Melville, New York 11747

Mytrex® CREAM AND OINTMENT, USP
(nystatin-triamcinolone acetonide)

Brief Summary of Prescribing Information

For Dermatologic Use Only
Not for Ophthalmic Use

INDICATIONS AND USAGE: For the treatment of cutaneous candidiasis; it has been demonstrated that the nystatin-steroid combination provides greater benefit than the nystatin component alone during the first few days of treatment.
CONTRAINDICATIONS: This preparation is contraindicated in those patients with a history of hypersensitivity to any of its components.
PRECAUTIONS: General: Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings (see DOSAGE AND ADMINISTRATION). Therefore, patients receiving a large dose of any potent topical steroid applied to a large surface area should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests, and for impairment of thermal homeostasis. If HPA axis suppression or elevation of the body temperature occurs, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis' function and thermal homeostasis are generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids. Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity (see PRECAUTIONS, Pediatric Use). If irritation or hypersensitivity develops with the combination nystatin and triamcinolone acetonide, treatment should be discontinued and appropriate therapy instituted
Information for the Patient: Patients using this medicine should receive the following information and instructions:
1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occluded (see DOSAGE AND ADMINISTRATION).
4. Patients should report any signs of local adverse reactions.
5. When using this medication in the inguinal area, patients should be advised to apply cream sparingly and to wear loose fitting clothing.
6. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.
7. Patients should be advised on preventive measures to avoid reinfection.
Laboratory Tests: If there is a lack of therapeutic response, appropriate microbiological studies (e.g., KOH smears and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens, before instituting another course of therapy. The following tests may be helpful in evaluating hypothalamic-pituitary-adrenal (HPA) axis suppression due to the corticosteroid: Urinary free cortisol test, ACTH stimulation test.
Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic or mutagenic potential or possible impairment of fertility in males or females.
Pregnancy Category C: There are no teratogenic studies with combined nystatin and triamcinolone acetonide. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Therefore, any topical corticosteroid preparation should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Topical preparations containing corticosteroids should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.
Nursing Mothers: It is not known whether any component of this preparation is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised during use of this preparation by a nursing woman.
Pediatric Use: In clinical studies of a limited number of pediatric patients ranging in age from 2 months through twelve years, Nystatin-Triamcinolone Acetonide Cream cleared or significantly ameliorated the disease state in most patients. *Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced hypothalamic-pituitary-adrenal (HPA) axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area to body weight ratio.* HPA axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches and bilateral papilledema. Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.
ADVERSE REACTIONS: A single case (approximately one percent of patients studied) of acneiform eruption occurred with the use of combined nystatin and triamcinolone acetonide in clinical studies.
Nystatin is virtually nontoxic and nonsensitizing and is well tolerated by all age groups, even during prolonged use. Rarely, irritation may occur.
The following local adverse reactions are reported infrequently with topical corticosteroids. These reactions are listed in an approximate decreasing order of occurrence: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae and miliaria.
DOSAGE AND ADMINISTRATION: Cream: Apply MYTREX® (Nystatin-Triamcinolone Acetonide) Cream, USP to the affected area twice daily in the morning and the evening by gently and thoroughly massaging the preparation into the skin. Ointment: A thin film of MYTREX® is usually applied to the affected area twice daily in the morning and evening. MYTREX® should be discontinued if symptoms persist after 25 days of therapy (See PRECAUTIONS, Laboratory Tests). MYTREX® should not be used with occlusive dressings.
Caution: Federal law prohibits dispensing without prescription.

SAVAGE LABORATORIES
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MELVILLE, NEW YORK 11747

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DOCTOR'S NEWS

ISMS MEDICAL EDUCATION FUND RECEIVES DONATION

The Henrotin Hospital Medical Staff donated $3,203.91 to the ISMS Medical Education Fund on March 31, 1988. This donation will be used for loans to third and fourth year medical students through the ISMS Medical Student Loan Fund Program. The donation represents residual monies from the medical staff fund at the time the hospital closed.

MEDICARE ADMINISTRATIVE EXPENSES DISCLOSED

The ISMS House of Delegates has directed ISMS to publish, on a continuing basis, specific financial information on the portion of dollars allocated for the health care of the elderly but spent on administrative expenses. The initial report reads as follows:

> During federal fiscal year 1987, Medicare Hospital Insurance Trust Fund (Part A) expenditures totalled $50 billion. Eight billion dollars, or 1.7%, was spent on administrative expenses. The Medicare Supplementary Medical Insurance Trust Fund (Part B) expenditures totalled $29.9 billion. Nine billion dollars, or 3.0%, was spent on administrative expenses. Overall Medicare administrative expenses were $1.7 billion or 2.1% of Medicare health care expenses.

MEDICAL VOLUNTEERS NEEDED

The fourth biennial North American Maccabi Youth Games will be held August 18-25 in Chicago and the north suburbs, it was announced by Edward L. Sclamberg, M.D., Evanston, medical director of the Games. Approximately 3,000 athletes from around the world, ages 13 to 16, will gather to participate in 13 different sports. Medical volunteers are actively sought to help during the events. Any physician, nurse, trainer, EMT, physical or occupational therapist, or other interested party should call the office of the Medical Director of the Maccabi Games at (312) 675-2200, extension 154.

MEDICAL HUMOR SOUGHT

A Springfield publishing company is seeking jokes and anecdotes for a compilation of medical humor. Contributors would be credited in the text. Persons wishing to forward material for consideration may contact Mr. James E. Myers, Lincoln-Herndon Press, Inc., 818 S. Dirksen Parkway, Springfield, IL 62703; (217) 522-2732. ◀



The World's Most Popular K*

Slow-K®

potassium chloride
slow-release tablets
8 mEq (600 mg)

It means "dependability" in almost any language

*Based on worldwide sales data on file, CIBA Pharmaceutical Company.
Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

1988, CIBA.

CIBA

128-3568-A

The World's Most Popular K

For good reasons

- ☐ **It works**—a 12-year record of efficacy[1]
- ☐ **It's safe**—unsurpassed by any other KCl tablet or capsule[2]*
- ☐ **It's acceptable vs liquids**—greater palatability, fewer GI complaints, lower incidence of nausea[2]
- ☐ **It's comparable to 10 mEq**—in low-dosage supplementation[3]†
- ☐ **It's economical**—less expensive than all other leading KCl slow-release supplements on a per tablet cost to the patient[1]



Slow-K®
potassium chloride
slow-release tablets 8 mEq (600 mg)

For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

CIBA

References: 1. Data on file, CIBA Pharmaceutical Company 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride bioavailability and safety *Pharmacotherapy* 1980;4(6) 392-397 3. Skoutakis VA, Carter CA, Acchiardo SR Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics *Drug Intell Clin Pharm* 1987;21 436-440

Slow-K®
potassium chloride USP
Slow-Release Tablets
8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE
BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.
1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function, potassium-losing nephropathy; and certain diarrheal states
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated

CONTRAINDICATIONS
Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE)

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS
Hyperkalemia (See OVERDOSAGE).
In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics
Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions
Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis
Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS
General:
The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients
Physicians should consider reminding the patient of the following:
To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests
Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions
Potassium-sparing diuretics, see WARNINGS

Carcinogenesis, Mutagenesis, Impairment of Fertility
Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C
Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers
The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use
Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE
The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics, (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml, (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION
The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED
Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

8 bottles of 100	NDC 0083-0165-30
8 bottles of 1000	NDC 0083-0165-40
Consumer Pack—One Unit	
12 8 bottles—100 tablets each	NDC 0083-0165-65
Accu-Pak® Unit Dose (Blister pack)	
8 ox of 100 (strips of 10)	NDC 0083-0165-32

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

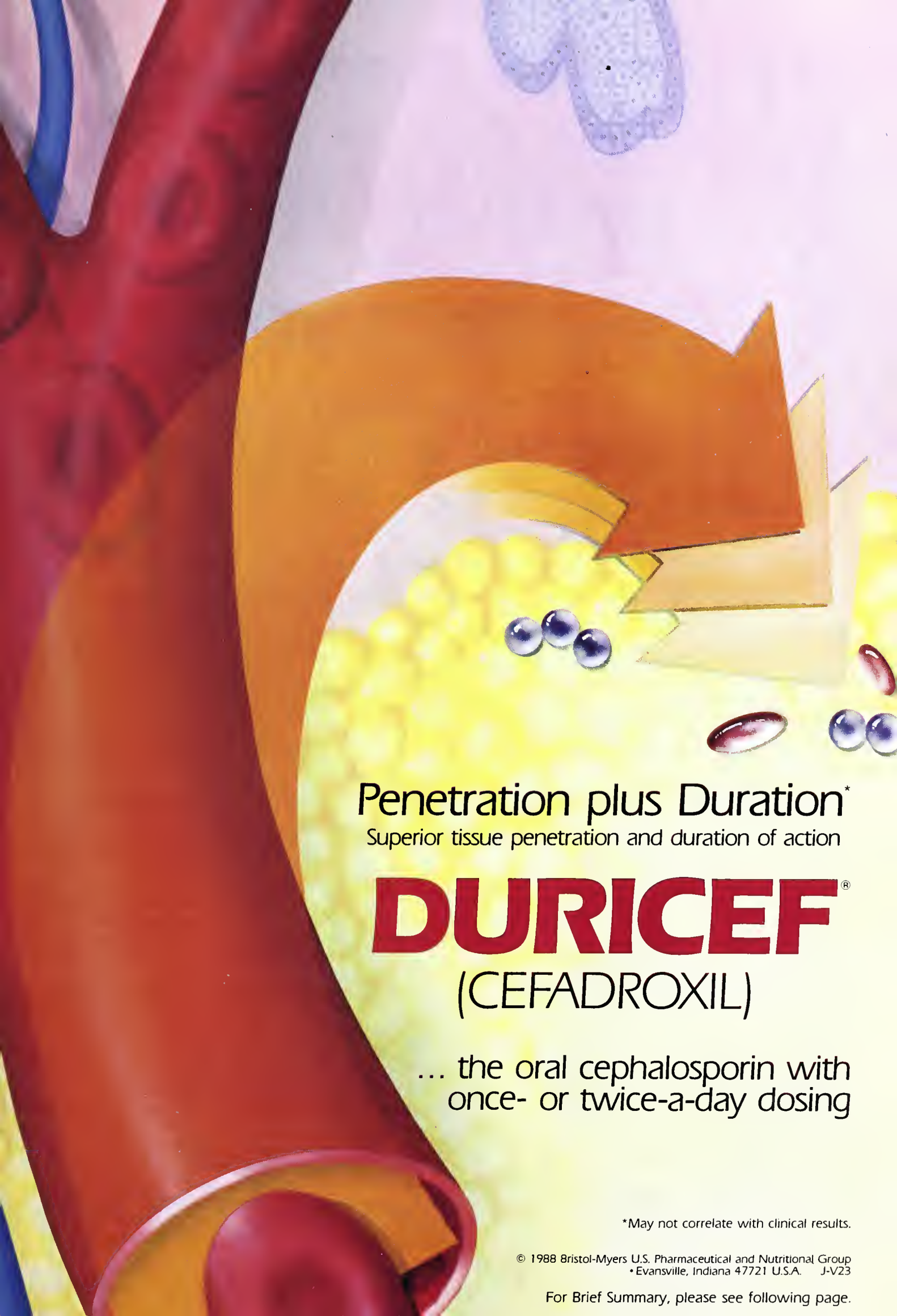
Dispense in tight, light-resistant container (USP)

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

C87-31 (Rev 8/87)

CIBA

128-3568-A



Penetration plus Duration*

Superior tissue penetration and duration of action

DURICEF®

(CEFADROXIL)

... the oral cephalosporin with once- or twice-a-day dosing

*May not correlate with clinical results.

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• Evansville, Indiana 47721 U.S.A. J-V23

For Brief Summary, please see following page.

DURICEF® (CEFADROXIL)
Penetration plus Duration in Oral Cephalosporin Therapy

INDICATIONS: DURICEF (cefadroxil) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms. Urinary tract infections caused by *E coli, P mirabilis,* and *Klebsiella* species. Skin and skin structure infections caused by staphylococci and/or streptococci. Pharyngitis and tonsillitis caused by Group A beta-hemolytic streptococci. (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. DURICEF is generally effective in the eradication of streptococci from the nasopharynx, however, substantial data establishing the efficacy of DURICEF in the subsequent prevention of rheumatic fever are not available at present.)

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

CONTRAINDICATIONS: DURICEF is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF PENICILLINS AND CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE).

Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil). **Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.** Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated. When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should also be considered.

PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

DURICEF (cefadroxil) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 ml/min/1.73M^2) (See Dosage and Administration section of Prescribing Information.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.

Prolonged use of DURICEF may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug. DURICEF should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to 11 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cefadroxil. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Caution should be exercised when cefadroxil is administered to a nursing mother.

ADVERSE REACTIONS: *Gastrointestinal*—Symptoms of pseudomembranous colitis can appear during antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug.

Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.

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PULSE OF THE ISMS AUXILIARY

A Privilege Often Ignored

By Pam Taylor (Mrs. Alan)

As American citizens, we know that we have the constitutional right and the civic responsibility to register to vote and then participate in the election process by voting. Unfortunately, although most know it, few actually do it.

The right to vote is important; those we elect represent us at the state and federal levels of government and shape policy and laws which affect us all. Because the actions of these elected representatives touch our lives daily, it makes sense for us to do all we can to become a part of the political process. This involvement is particularly important to the medical profession, as physicians are increasingly facing government intrusion and bureaucracy in their practices. The Illinois State Medical Society is comprised of 17,000 members and 2,300 Auxiliary members. These two groups combined add up to quite a large voting force!

Over the years political analysts have offered various reasons for the lack of involvement in the election process. One reason that stands above all others is that "the registration process is inconvenient." Rather a sad commentary, considering the impact of this process on our lives; a process which many throughout the world fight for daily.

Recognizing this problem, the Illinois State Medical Society Auxiliary will once again sponsor a voter registration drive. In the coming months county auxiliaries throughout Illinois will actively encourage physicians and their families to register to vote. Special voter registration booths sponsored by the Auxiliary will be installed in hospitals and at county medical society meetings, to name a few locations. These auxilians are volunteering their time to help take the "inconvenience" out of the election process. If you are not yet registered to vote please take a couple of minutes and do so. The rewards of participating in the election process are many; the consequences of not doing so can be profound.

Registration is only the first step in the election process. The next step, voting, allows us to elect representatives who will shape policies affecting the medical profession and the public it serves. Please do not ignore this important constitutional right. Become a participant. Once registered, please VOTE in the November 8th elections. You really can't afford not to. ◀

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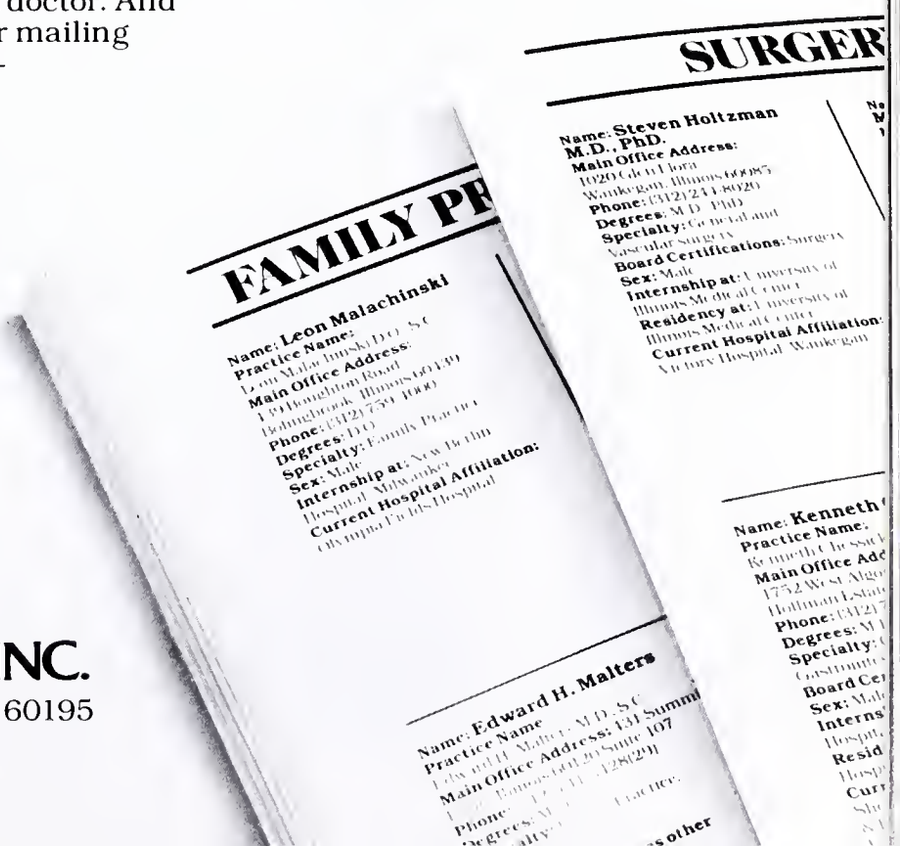
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Physician/Patient Relationship Prevails

BY JUDEE GALLAGHER, J.D.

What happens when you receive notice from an HMO that it intends to terminate your contract? Can you tell your HMO patients of what they must do if they want you to continue to be their doctor? Yes, according to a recent California court decision. The court considered this question in the aftermath of a lengthy, hotly-contested arbitration which led the HMO to terminate its long-standing contract with the multi-specialty medical group whose patients included over 100,000 HMO members.

Contract termination in this case meant that individuals could no longer be both HMO members and patients of the medical group. The HMO would no longer pay for care rendered by the group. Individuals would have to choose whether they wished to stay with the HMO or keep their doctors.

The same day the HMO canceled its contract with the group, it notified by mail the benefits managers of several employer groups and the group's patients and informed them of the contract cancellation. The HMO letter stated that patients were required to transfer to doctors who had a contract with the HMO, suggesting that the physician/patient relationship ended with contract termination. Apparently this letter generated confusion among the group's patients. The group responded by sending its own letter, which stated that patients could continue seeing their group doctor if the patient chose a new HMO. The letter listed several HMOs under contract with the group from which the patient could choose.

To stop this, the HMO filed suit, alleging unfair competition and trade secrets violations by the group. The HMO maintained that its single most valued asset was its members, pointing to the fact that when an HMO is sold the price of the company is based on a per capita valuation of the members plus the fixed assets. It argued that the group was soliciting members to join other HMOs and was using its membership lists to do so. It characterized the group's communication with its patients as "an attack on the very fabric of the company."

The judge assessed the group's actions differently. While recognizing both the group's economic interest in maintaining its patient base and the competing economic interest of the HMO in maintaining its membership, the court focused on the unique nature of the physician/patient relationship. The court believed it was appropriate for the group physicians to let their patients know: "Here's what you have to do to stay with me." The trust and confidence patients place in their physicians make their relationship different from other com-

mercial relationships. To dramatize the point the court made an analogy to a mythical CMO (car maintenance organization). To maintain their cars, owners pay a fixed monthly fee to the CMO, which in turn contracts with garages. But, if the CMO terminates a contract with a garage, no body of law protects the mechanic/car owner relationship. The court refused to allow the HMO's commercial interest to intrude on the physician/patient relationship, or dilute either the physician's right to communicate with patients about their health needs or the patient's right to receive this information.

Some contracts between physicians, or physician groups and HMOs contain provisions which restrict the physician's right to communicate with their patients upon contract termination. Others give the HMO the right to transfer patients to other providers as soon as it gives or receives notice of contract termination. But contract termination does not necessarily end the physician/patient relationship. These provisions should be carefully scrutinized and the ramifications should be fully understood.

Your attorney has undoubtedly explained that when you are considering an Individual Participation Agreement with an HMO, PPO or IPA you may not band together with other physicians to negotiate the contract collectively, because that violates antitrust laws. You can, however, individually negotiate your own contract by yourself or with your personal attorney or financial advisor.

Acknowledgement

The author would like to thank Jay Woollacott, J.D., Los Angeles, California, for discussing this case and providing a transcript of the hearing and other court documents.

Judee Gallagher, J.D., is a Chicago private practice attorney retained by the ISMS Office of Contractual Services since 1985.

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Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LO_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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Progress for the Profoundly Deaf

Cochlear Implants

By Richard J. Wiet, M.D., Edwin M. Monsell, M.D., Ph.D., Cathleen A. O'Connor, M.S., and Teresa A. Zwolan, M.A./Hinsdale

Cochlear implants are devices which provide sound perception in the profoundly deaf through electrical stimulation of the inner ear. After evaluation, patients undergo a surgical procedure followed by auditory rehabilitation. Several implant programs are underway in Illinois. We present a description of two FDA-approved devices and our experience with them in fifteen patients. Cochlear implants are not a panacea for all types of deafness, and auditory perception with an implant is not normal hearing. Nevertheless, properly-selected patients often benefit sufficiently to function in the hearing world. For example, two of our patients have open-set speech discrimination. Criteria for referral to a cochlear implant team are described.

The modern technique of electrically stimulating the inner ear to provide sound perception in the profoundly deaf began experimentally in France by Djourno and Eyeres in 1957.[1] A wearable, marketable device was first created when William F. House of Los Angeles found corporate support from the 3M Company.

More recently, a 22-channel device developed by Professor Graeme Clark and the Cochlear Corporation (Nucleus Group) of Australia was also released by the FDA. Other multi-channel devices under development at this writing include the University of California at San Francisco device (manufactured by Storz) and the University of Utah device (manufactured by Symbion). The UCSF and Utah devices are currently available only through research programs.

In December of 1981 Illinois's first cochlear implant was performed by Richard J. Wiet, M.D. Working with Dr. House, Dr. Wiet was a member of the original clinical team under an Investigational Device Exemption from the FDA.

To date, our group has implanted 15 adult patients with either the House-3M (N = 10) or the Nucleus 22-Channel Cochlear Implant System (N = 5).

Materials and Methods

Cochlear Implant Devices

All cochlear implant devices have in common a microphone, a speech or signal processor, an electrode array inside the inner ear, and a means to transmit the signal to the internal electrodes. The devices differ significantly in their details, particularly in their strategies of coding sound and stimulating the cochlea. Devices also change periodically as improvements are added.

With the House-3M Cochlear Implant the electrical signal is filtered (band pass 340 to 2700Hz) and used to amplitude modulate a 16KHz sinusoidal carrier wave. The electrical signal is then conveyed to the implanted internal coil receiver through the intact skin by a magnetic induction coil. The signal is delivered to the monopolar ball electrode, which is inserted through the round window 6mm into the scala tympani. The patient controls the volume and microphone sensitivity within preset levels. This device provides rate and intensity information, but frequency discrimination is poor above 800Hz.[2]

The Nucleus 22-Channel Cochlear Implant System extracts and encodes three specific components of the speech signal useful for speech understanding. After encoding, the signal is sent to the receiv-

er/stimulator through the intact skin via a radio frequency transmitter. The receiver/stimulator carries the signal to the implanted array of 22 electrodes, which is inserted 20mm into the scala tympani. The speech processor is programmed by a computer to match the threshold and loudness for each bipolar pair of electrodes selected. This programming takes longer than for other devices, but enables separate areas of the cochlea to be individually stimulated, making more pitch discrimination possible. Enhanced pitch discrimination seems to offer most users improved speech perception.[3]

Patient Evaluation and Selection

To be a potential candidate for a cochlear implant, a patient must be profoundly deaf in both ears, demonstrate a patent cochlea, and receive no benefit from a hearing aid.[3]

The initial evaluation consists of a general and neurotologic medical history, physical examination, and basic audiometric tests. Matters of particular interest include the cause, duration, and extent of hearing loss, previous and current use of amplification, and ability to manage communication problems related to hearing loss. In some cases stapes surgery, a more powerful hearing aid, or an assistive listening device may be more appropriate than a cochlear implant.[4]

Most importantly, the patient and family are counseled in depth about cochlear implantation. Topics covered early in counseling include how a normal ear works, how a cochlear implant works, the potential benefits, risks and limitations of the cochlear implant, postsurgical rehabilitation, patient motivation and financial responsibilities. An actual device is demonstrated and the patient meets with an implant user.

Computed tomography of the inner ear is performed to evaluate cochlear patency and to detect any congenital anomaly. Bone growth, most commonly seen in cases of deafness due to meningitis or otosclerosis, may require cochlear drilling and increased stimulus power. Some anomalies, such as the common cavity variant of the so-called Mondini malformation, may require the selection of a short electrode implant, such as the House-3M device. We perform transtympanic electrical stimulation of the otic promontory as a guide to prognosis. Vestibular function (electronystagmography), auditory brainstem response, vision, and, when indicated, psychological status are assessed.

As of December, 1986, ten profoundly deaf adults have been implanted by our group with the House-3M Single Channel Cochlear Implant. Subjects ranged in age at the time of surgery from 18 to 61 years, with a mean of 42 years. The age at onset of profound hearing loss ranged from 3 to 60, with a mean age of 34 years. The duration of profound deafness varied from one to 27 years, with a mean of seven years. The etiology of profound hearing loss included: unknown (4); trauma (2); ototoxicity (1); congenital (1); meningitis (1), and otosclerosis (1).

During the original clinical trials with the House-3M Cochlear Implant, speech evaluation was performed in accordance with FDA protocols. The best preoperative test results (hearing aid), were compared with the cochlear implant test results after rehabilitation. Testing included speech awareness threshold (SAT), spondee, uncomfortable loudness level (ULL), Monosyllable-Trochee-Spondee (MTS) test[6] and the Environmental Sounds (ES) test.[7]

More recently, our multichannel patients have been evaluated using the Minimal Auditory Capabilities Battery (MAC),[8] the Iowa cochlear implant battery, and the Northwestern multimodal speech discrimination battery. These tests were developed to evaluate the auditory discrimination ability of profoundly deaf patients using prosthetic devices. Subtests range in order of difficulty from speech sounds to the comprehension of words and sentences. Analysis of the errors made by the patient in these tests is used in the development of the patient's postsurgical rehabilitation program. MAC battery and speech tracking data are presented later in this paper on two multichannel patients who have completed initia rehabilitation.

Postsurgical Management

Fitting of the headpiece and wearable speech processor of the Nucleus 22-Channel System typically requires nine hours of clinical contact over a three-day period during which time the device is reprogrammed. Fitting the House-3M external device is accomplished in less than one hour due to its simplicity.

After initial fitting, patients are seen twice a week for six to ten weeks for communication training and rehabilitation with the device. Rehabilitation may continue as long as necessary. Patients are also encouraged to join local support groups. Following initial rehabilitation, patients undergo annual otologic and audiologic follow-up.

Results

Clinical Experience with the House-3M Single Channel Cochlear Implant

Of the ten single channel patients, six currently wear the unit daily, one patient wears it sporadically (approximately three days a week). Three patients are non-users; two of these patients had internal device failures and are considering revision with the multichannel cochlear implant system, one is not satisfied with the unit. One patient had a successful revision after failure of the internal device and is now a full-time user.

Mean figures are presented in Figure 1 and Table 1 for pre-implant unaided, pre-implant aided, and cochlear implant responses. Ling and Ling[9] reported average conversational speech at six feet occurs in a spectrum. This has been plotted by frequency and intensity level in Figure 1. The figure shows warble tone thresholds and demonstrates that after implantation, but not before, patients are generally able to detect the sounds of normal conversational speech. Warble tones are test stimuli that oscillate in frequency within a narrow range close to the center frequency indicated. They are used

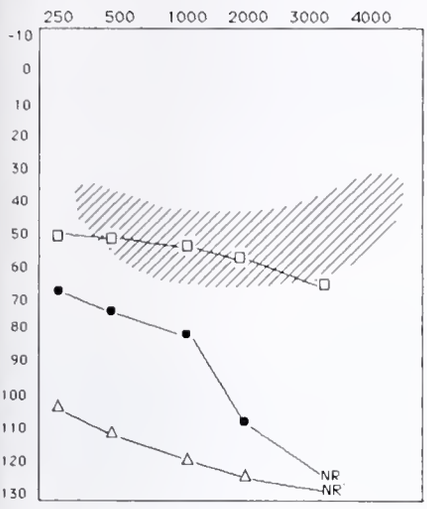


Figure 1
Mean patient warble tone sound field thresholds in dB HL are presented for frequencies in Hertz for nine patients receiving the House-3M Single Channel Cochlear Implant System; preoperative unaided (triangles), preoperative aided (dark circles), and postimplantation (squares). Mean responses were calculated by assigning a value of 130 dB SPL when no response (NR) was obtained.

Table 1
Correct Scores in Nine Patients with House 3-M Single Channel Cochlear Implants
Mean, Median, and Range of Pre-Implant Unaided, Pre-Implant Aided, and Post-Implant Discrimination Scores (in Percents).

	MTS Word	MTS Stress	Environmental Sounds
Pre-Implant Unaided			
Mean	0.1	1.1	0
Median	0	0	0
Range	0-1	0-10	0
Pre-Implant Aided			
Mean	5.9	7.8	4.7
Median	0	0	0
Range	0-22	0-24	0-20
Post-Implant Discrimination			
Mean	8.7	21	10
Median	10	23	11
Range	1-16	11-24	7-16

Table 2
Pre- and Post-Implant Minimal Auditory Capabilities (MAC) Test Battery Results in Two Patients with Nucleus Multichannel Cochlear Implants

Subtest	Number of Items	Chance Score	Case 1 Pre	Case 1 Post	Case 2 Pre	Case 2 Post
I Question/Statement	20	10	11	20	6	9
II Vowel Discrimination	60	15	12	37	1	23
III Spondee Recognition	25	—	0	8	0	0
IV Noise/Voice Discrimination	40	20	24	38	26	34
V Accent	20	5	6	19	5	4
VI Everyday Sentences	100	—	0	41	0	1
VII Initial Consonants Discrimination	64	16	16	29	10	23
VIII Spondee: Same/Different	20	10	9	19	8	16
IX Words in Context	50	—	0	DNT	0	0
X Familiar Sounds	15	—	1	6	1	1
XI Monosyllabic Words	50	—	0	5	0	0
XII Four-Choice Spondees	20	5	6	15	7	12
XIII Final Cons. Discrimination	52	13	12	46	1	23

because testing patients with rehabilitative devices (hearing aids and cochlear implants) must be done in a sound field, where pure tones are subject to distortion from reverberation. Preoperatively, many patients had no response or only vibrotactile response at the frequencies tested.

Detection of sound at the frequency and intensity levels of speech is an important indication of performance, but does not necessarily mean that a patient is able to achieve usable discrimination of this sound. The MTS word and stress tests and environmental sounds (ES) tests offer a more realistic indication of performance.

Performance on the MTS word and stress discrimination and environmental sounds tests pre- and post-implant can be seen in Table 1. Post-implant scores are consistently better than results with the hearing aid. Prior to implantation, most patients could barely detect the test stimuli.

The House-3M device provides little frequency information that is useful in speech discrimination, but provides valuable timing and intensity cues. Although our House-3M patients cannot understand speech with the implant alone, rhythm, syllabication, and stress patterns enhance speech reading. Our House-3M implant patients find that the implant greatly aids in communication, increases accuracy in speech reading, and improves their ability to monitor their own voices.

Clinical Experience with the Nucleus 22-Channel Cochlear Implant System

Our results with two multi-channel patients who have completed rehabilitation are presented below as case reports. Three additional patients have undergone postimplant rehabilitation and evaluation. Prior to implantation all five patients had no responses in sound field testing unaided.

Case One

A 22-year-old college student developed a bilateral sensory hearing loss of unknown cause that began in 1981 and progressed to a profound loss in 1985. She used progressively more powerful hearing aids as her hearing worsened, but for nine months prior to implantation was unable to benefit even from the most powerful aids. MAC battery results (Table 2) show marked improvement with the implant, compared to preoperative scores, especially in subtests VI (everyday sentences) and XI (monosyllabic words), two measures of speech discrimination. Most remarkably, this patient has excellent speech tracking and has true open-set speech discrimination, *i.e.*, understanding of speech in new material with the implant alone.

Case Two

A 53-year-old school engineer lost his hearing at the age of 10 due to congenital lues, and had no history of hearing aid use. MAC battery results show a marked improvement in performance with the implant compared to preoperative aided responses. (Table 2) Overall, the greatest amount of improvement with the device was demonstrated by the patient's ability to discriminate consonants (subtests VII, XIII) and vowels (subtest II).

During rehabilitation the patient became frustrated with his inability to understand words with the device alone. He was shown how the device could be used to improve his communication ability by combining use of the processor with lipreading. He currently wears his device "all the time" and has stated that use of the processor substantially improves his communication ability. He is currently learning to speak Italian, an accomplishment he feels would not have been possible prior to receiving his implant. These results were gratifying in view of the patient's 43 years without sound.

Discussion

In 1983 the Council on Scientific Affairs of the American Medical Association endorsed the cochlear implant as an acceptable procedure for postlingually profoundly deaf adults. Cochlear implants in adults have gradually gained world-wide acceptance, and have had a very favorable safety record.[10] Clinical trials are underway in children.[11,12] We have had no surgical complications in our series. Cochlear implants are covered by most insurance programs, including Medicare.

Our experience with cochlear implants has been positive. We have found that the single-channel House-3M device has provided sound awareness, the ability to recognize some everyday sounds, and has enhanced speech reading by providing intensity and timing cues. In our limited comparative experience the Nucleus multichannel device appears to offer better speech reading performance; two patients have open set speech discrimination.[13] Research continues worldwide to improve devices and compare performance.[14]

Cochlear implantation is appropriate for a limited population which cannot be helped by middle ear surgery or nonimplantable devices. The sound provided is not normal sound, and performance varies. The difference in performance between our multichannel patients can probably be attributed to their differences in age, etiology of hearing loss, and the interval between the onset of deafness and implantation. Health care professionals should have a caring, encouraging attitude, but work to keep expectations reasonable.

Because of their knowledge of the pathophysiology of hearing loss, audiology, and temporal bone radiology, otolaryngologists are the logical persons to evaluate the potential cochlear implant candidate. Their work, in cooperation with the rehabilitative audiologist, begins the referral line to those physicians equipped to treat the profoundly hearing impaired.

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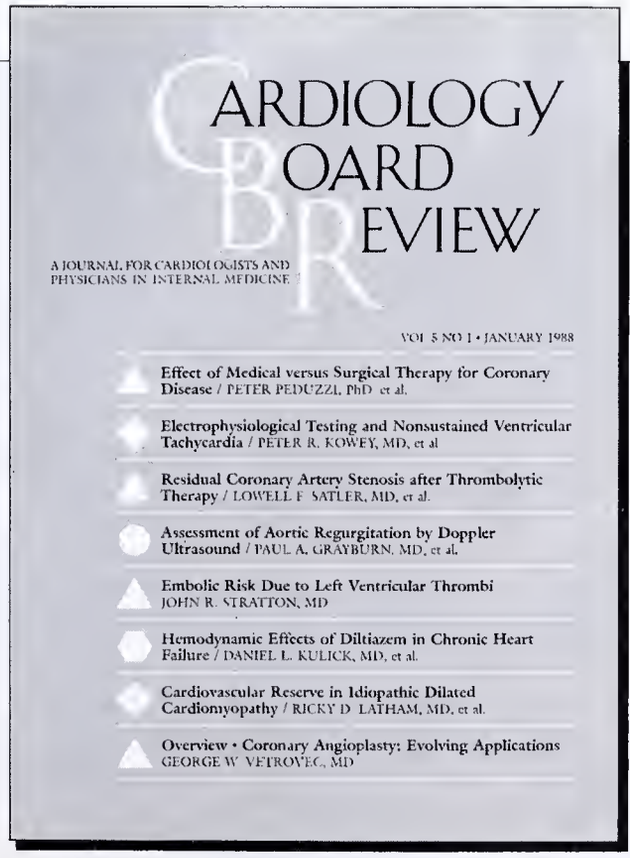
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A Committed Physician

Daniel A. Carrion: 1858-1885

By Pedro A. Poma, M.D./Melrose Park

Bartonellosis, or Carrion's disease, was a disorder of high mortality endemic to South America in the late nineteenth century. A medical student, Daniel Alcides Carrion, performed the first scientific study of this disease. The circumstances which led him to this experiment and current clinical aspects are presented.

The ancient dictum "To cure sometimes, to relieve often, to comfort always," is a philosophical guideline for physicians. The opportunity to help patients recover and remain healthy has always been considered a privilege.

There have always been men and women, driven by higher ideals, who have exceeded their traditional responsibilities. In order to treat an illness, they either acquired that illness, or used themselves as guinea pigs for experimental purposes.[1]

John Hunter inoculated himself with a patient's secretions to test his hypothesis that syphilis and gonorrhea were one disease. He died from luetic cardiovascular complications. Horace Wells, a dentist, first used nitrous oxide as an anesthetic agent by experimenting on himself. Max Von Pettenkoffer ingested the cholera bacillus to demonstrate that it was not the etiological agent of cholera. Luckily, he survived, but his hypothesis was indeed incorrect. Hideyo Noguchi, Adrian Stokes, and Jesse Lazear each conducted scientific experiments at great personal risk which lead to progress in treatment of yellow fever. Similarly, William Harrington's work led to greater understanding of idiopathic thrombocytopenic purpura.[2]



Daniel Alcides Carrion. (Illustration courtesy of Dr. Anibal A. Pepper)

The Rimac Valley

The Inca Empire was the leading civilization in South America before the Spanish arrived. Located on the Pacific Ocean side of South America, the area comprised what is today Peru, and parts of Argentina, Bolivia, Ecuador and Chile.

In 1535, Francisco Pizarro, the Spanish conqueror, founded Lima where the Rimac River flows into the Pacific Ocean.

In the late nineteenth century, a legend popular in the Rimac Valley described a local demon who hid in the daytime and hunted invisibly during the night. Only tiny sand flies would follow it. A luckless human touched by the demon would grow warts (verrugas). Local inhabitants usually recovered; foreigners most often died.[1]

La Oroya Fever

During this time an edemic disease with high morbidity was named La Oroya fever because it was associated with construction of the Lima-LaOroya railroad. Deaths occurred primarily at the mouth of the Rimac Canyon, but the disease was named for the final destination of the railway workers who fell prey to it. LaOroya fever was characterized by sudden high fever, extreme pallor, weakness and precipitous drop of RBC count.[3]

Blood cell count would drop to one million in 4-5 days with change in size and staining of RBCs, including nucleated RBCs. There might be mild leukocytosis with shift to the left. The patient would complain of severe muscle and joint pain, headache and insomnia. Salmonellosis, malaria, amebiasis, and tuberculosis were often present. Delirium and coma were terminal manifestations. In non-treated patients, mortality exceeded 50%; death occurred within 10 to 30 days.[3]

Verruga Peruana

Another disease shared similar geographic confines and was characterized by eruption of warts (verrugas). Eruption was accompanied by pain, fever and moderate anemia and sometimes occurred in asymptomatic patients. The nodular verrugas varied from red to purple in color and were from 2mm to 4cm in diameter. They were intact or eroded and persisted one month to two years. Eruption takes successive crops: verrugas of all sizes, types and stages of development. They were common on the limbs and face, less-frequently seen on the genitalia, scalp and mucosa and have been described in every bodily organ. Verrugas are not tender, and symptoms depend upon location. In the regression stage, verrugas became pale and changed histologically from angioblastic to fibroblastic. The presence of this disease, noted since the pre-Incan civilizations, was first described in literature in 1630 by Gago de Vadilla.[4]

Daniel Alcides Carrion

Carrion was born August 13, 1858 at Cerro de Pasco, a town in the Andes about 175 miles from Lima.[1]

At 15, Daniel was sent to Lima to continue his studies via the La Oroya Railroad. There he saw individuals with verrugas. Apparently, their sad appearance made a lasting impression on the boy. He enrolled in the Colegio Guadalupe, a well-respected secondary education school in Lima, continued premedical studies at San Marcos University in 1879 and later studied at San Fernando Medical School.[1]

In 1881, Chilean invasion forces were landing in Lima. The regular Peruvian forces had been vanquished. Daniel and thousands of other students defended the capital in San Juan and Miraflores, the last battles fought at Lima's outskirts. The majority of Lima's educated youth died in this futile attempt. The enemy took the capital. The medical school was converted into foreign troop quarters. Only action by European powers prevented the final destruction of the national library, which housed important archives and other national art treasures. Daniel returned to his studies at a school with no library, no educational tools, and hospitals in ruins. Because the main port was blocked, there was no communication with the outside world, much less scientific information.[1]

In Europe at this time, Koch had begun pioneering work and Pasteur had just vaccinated sheep against anthrax. The sciences of bacteriology and pathology were in their infancy. The practice of medicine was empirical and relatively primitive. The sciences had yet to influence medical education.

In 1882 the understanding of LaOroya fever (OF) and Verruga Peruana (VP) was very limited. Finding a cure was, perhaps, less a challenge than were the economic and political debacles. As a requirement of graduation, medical students prepared and defended a thesis, preferably an original study. A Chilean physician, Izquierdo, was convinced that OF and VP were two diseases. A Peruvian physician, Salazar, believed the two diseases were the manifestation of the same illness. However, neither Izquierdo nor Salazar left any evidence supporting their positions.[4]

In 1885 European scientists had become interested in these diseases and were requesting specimens for study. The Free Academy of Medicine in Paris offered a monetary award to the person whose contribution facilitated the understanding of these illnesses. During this season, only a few patients affected by verrugas remained in the hospital. Fourteen years had elapsed since more than 7,000 railroad workers had died of the disease during construction of the Lima-LaOroya Railroad.[4]

On August 27, 1885, Daniel, then a senior medical student, took a lancet from the lab and decided to conduct his own experiment. He pierced a patient's verruga and tried to stab himself in the forearm. Overexcited, he was unable to do it. A friend had to assist him with the inoculation.[5]

While continuing his duties Daniel kept a record of every important event. Twenty-one days after inoculation, he noted fatigue. A day later, he noted left ankle pain and soon after, pain at motion and a temperature of 103.6. Hematuria, chills, temperature of 104.9 and flea-bite like spots appeared within the next three days. Writing became difficult because of muscular stiffness. Severe symptoms followed. During periods when he felt somewhat better, he discussed the pathogenesis and the prognosis of the disease. Because the inoculum from a wart causes the fever stage, Daniel waited for the verrugas to appear. (Verrugas would indicate that the patient was saved.) His friends were very concerned, because the disease was taking a very exhausting toll. "Don't worry my friends," he said. "I'm not dead yet."[4]

During the next week, a faculty member visited him at home and offered him a blood transfusion, which he refused, fearing it would alter the natural course of the disease. Later, he finally agreed to hospitalization.[4]

His death occurred October 5, 1885, just 39 days after the inoculation.[4,5] Daniel Carrion demonstrated that Oroya fever was caused by verruga inoculation. A homocide investigation was started against the friend who assisted Daniel with the inoculation and a faculty member who was also present. (These charges were later dropped.) Daniel A. Carrion's body was carried on the shoulders of his friends and classmates through Lima's streets to his final resting place.[4]

Carrion's Disease

Bartonellosis was named for Carrion because his experiments were the first serious efforts to discover its pathogenesis. This disease only

occurs in certain valleys of Peru, Colombia and Ecuador, where the Phlebotomus verrucarum (sand fly) resides.[4] We now know that both stages of this disease can be mild, constituting the greatest epidemic hazard: asymptomatic and convalecent reservoirs. In 1926, Noguchi confirmed on monkeys that Oroya fever and Verruga Peruana were stages of the same disease. The etiological agent is an intraerythrocyte bacillus, *Bartonella bacilliforme* named after its discoverer, Peruvian Alberto Barton (1905). Ninety percent of RBCs are invaded by a small, motile, aerobic, pleomorphic gram-negative bacilli, reddish-violet at Giemsa's stain. Blood cultures are positive in both stages of the disease. Second attacks are unusual, and if they occur, only dermatological lesions are noted. The attacks provide life immunity. Carrion's disease has an incubation time of 3 to 14 weeks. Its onset can be insidious or abrupt.[4]

Mosquito nets can prevent the spread of the disease. Blood transfusions were used as a treatment in the past. Only after WW II, when penicillin became available, were satisfactory results obtained. Today, tetracycline and chloramphenicol, each at two grams a day for seven days, are recommended. Fever usually disappears in 48 hours. In the eruptive stage antibiotics may hasten evolution of lesions.[4,6]

Conclusion

Many practicing physicians and researchers have died as a result of voluntarily submitting themselves to disease to relieve suffering and prevent death.[2] Carrion was an unknown medical student, studying an obscure Peruvian disease. His experiment had little or no impact in the Western medical community and was minimally addressed in the English literature.[4]

Medical self-experimentation contains some common elements:[4] heroism; tragedy; and most importantly, the advance of knowledge. Was Carrion a martyr or a naive young student? Some still wonder. In Peru, he has become the foremost hero of medical history, an example of what one individual can do despite adversity. ◀

Acknowledgement

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The Care Center Cares

In 1978, Springfield, Illinois' community leaders, physicians and social service professionals had a common problem: how to battle stubbornly high infant mortality and teen pregnancy rates, and how to get indigent women linked up with appropriate medical care and other needed resources. Fifteen of them came together to discuss just what could be done. Their enthusiasm and concern resulted in the Care Center of Springfield, which opened its doors on May 5, 1979 and has served Springfield's prospective mothers ever since. This year, the Care Center of Springfield received the Illinois State Medical Society's top nonphysician honor, the 1988 Public Service Award. This month IMJ *profiles the Center's strategies and successes that earned them the respect and support of Springfield's medical profession and the community at large.*



Care Center staff (left to right): standing—Ester Welch, Erin O'Neill, Joan Reardon; seated—Linda Eck, Carolyn Bodewes, Fritzie Belz.

"We've got to get them to the physician. That's the bottom line," asserts Care Center project director Carolyn Bodewes. "Nothing is above and beyond the Care Center's services if it's affecting a young woman's inability to access prenatal care." But that is by no means the sum and substance of the Care Center's advocacy for prospective mothers with problem pregnancies, some 500 of whom walk through the Center's doors annually. A raft of individually-tailored services are what make the Care Center stand out in the minds of their clients. Going that extra mile on behalf of those in need has also won them the hearts of Springfield's medical community, which nominated the Care Center for this year's Illinois State Medical Society Public Service Award.

The Center's philosophy "sounds a little bit corny, but we've found that it's true," says Bodewes. "If you take care of the mother, then the mother will take care of the baby. We help her get in a position in which she can have some income, take stock of who she is and build her own self esteem. Many of these girls have never realized that there is an 'I' to want," she assesses.

If you take care of the mother, then the mother will take care of the baby.

A Respect for Life

Dr. John Young, a Springfield obstetrician and founding member of the Care Center agrees, citing the Center's "highly personal attention" as key to its success with clients and physicians. While Care Center services have expanded markedly over the last eight years, Young believes that original philosophy has persevered and even grown stronger.

Originally the Care Center sprang from the pro-life concerns of its organizers. "There was a certain pro-life feeling among most of us organizing the Care Center," Young explains, but stresses that the Center has moved well beyond that initial focus. The organization's bylaws state that the "Center is founded on the premise that abortion is never a solution to a problem, nor acceptable as a means of birth prevention; no aid will be given to secure an abortion and all other alternatives will be considered. If a client has decided to have an abortion, she will be advised in a nonjudgmental manner that the Care Center does not make referrals for this service, but that other local agencies do so, and that, regardless of her decision, the services of the Care Center are available to her."

Enlisting the Medical Community's Support

How did the Center enlist the crucial participation of area doctors? "We asked them point blank, 'Will you take care of these patients free?' " says Young. A nucleus of physicians responded positively, and therein lies the medical backup so necessary to Care Center success. "That is indeed a great strength of the Care Center, in contrast to other social service agencies that may not have quite that level of physician support," Young emphasizes. "The Center can call a doctor and ask you to see a patient today."



Counselor Joan Reardon.

William Simpson, M.D., who practices just up the street from Care Center offices, says that local doctors first thought of the Center as "just another organization." But that impression didn't last. "I think now doctors realize the Center does a great deal of good." That's why, he believes, the number of physicians helping the Care Center has continued to increase, even in these troubled times of low Medicaid reimbursement and costly medical malpractice insurance.

What services has the Care Center provided for Simpson and his patients? "They've given out prenatal vitamins, or at least instructions on how to get them—especially if the state won't reimburse. They monitor patients' little, nagging problems, which often don't seem small to women who may be indigent and alone during pregnancy. The Center spots trouble signs we should discuss with these patients, and they can intervene in family problems, too," he enumerates. Helping clients find a place to live, locate employment opportunities, learn a trade, get into a community college, prepare for graduate equivalency degrees or land a scholarship are Care Center "extras" provided by staff. And very important to physicians is the Care Center's diligence in monitoring patients to assure doctor's appointments are kept.

Cooperation between physicians and the Center is a two-way street, with doctors referring troubled

The number of physicians helping the Care Center has continued to increase, even in these troubled times of low Medicaid reimbursement and costly medical malpractice insurance.

The Care Center Understands

The Economics of Delivering Babies in Illinois

The following is an excerpt of Care Center counselor Joan Reardon's testimony before the Congressional Select Committee on Children, Youth and Families, October 5, 1987, Springfield, Illinois.

As a counselor at the Care Center of Springfield, a small agency that has as its primary clients women experiencing stressful pregnancies, I am aware of the struggle many of these women face in attempting to access medical care. Many of these women have Medicaid cards. Others are attempting to enter the Public Aid system for the first time in order to secure the necessary funding to receive medical care. Some are among the working poor, employed in poorly paid fields. Each category presents its own particular problem.

Women who have their cards often report an unsuccessful attempt to locate a physician who will accept this particular form of payment. Those attempting to secure a card for the first time often find themselves overwhelmed by the long list of necessary documentation which must be provided in order to be accepted by the system. Those who are working are often accepted for public funding with a spend-down amount that is outside their ability to meet and virtually proves to be worthless during the initial stages of pregnancy. . . .

. . . . I have been employed by this agency since June of 1980. In this period of time, I have never been refused medical care for any of our indigent pregnant women. We have enjoyed the support of several dedicated, extremely competent physicians who have cared for the women we have referred to them. They have done this, trusting that our agency will pursue all available means of funding, but also knowing that the current Medicaid funding level of $446.50 will not cover their basic office expenses. Much of the early prenatal care provided comes out of these doctors' own pockets. They carry a disproportionate share of the burden of indigent care within our community, for there are many other qualified physicians who refuse to accept these women under any circumstances. As the number of referrals made by our agency increases, the burden on our supporting physicians continues to show a corresponding increase. At the same time this is occurring, medical malpractice insurance rates for obstetricians are escalating at an unprecedented rate. One of our supporting physicians reports an increase of $59,000 (from $37,000 in November 1986 to $96,000 in November 1987) per doctor in his practice. Since this cost and the costs of his equipment, staff salaries, operating expenses, etc., must come out of his patient charges before he makes his own profit, it does not take a great deal of thought to understand why he must limit the number of public aid patients he can care for. His delivery charge for complete antepartum, delivery and postpartum care is $1,500, one of the more reasonable in our community. Based on current I.D.P.A. rates, he will be paid less than ⅓ of his normal charge.

Due to our ability to access care for pregnant women, we do receive a number of requests from other community agencies to provide this service. I believe we have been successful in maintaining a working relationship with our doctors because of our proven ability to share the burden of care for these women. Our services are complete in providing close followup, which encourages compliance with medical appointments, providing emotional support through counseling, continually stressing the role of adequate nutrition and providing prenatal health education. All of these factors impact favorably on giving birth to healthy infants and reduce the number of complications which add a further burden of time and care to the physician.

In summary, I believe that the problem of providing access to medical care for the poor is a complicated one which does not lend itself to a single, isolated course of action. ◀



Dr. William Simpson sees a steady flow of patients from the Care Center.

Cooperation between physicians and the Center is a two-way street, with doctors referring troubled patients presenting in medical offices for counseling and other support services.

patients presenting in medical offices for counseling and other support services. "Doctors often call us when someone in their office is not coping well after receiving a positive pregnancy test. Or perhaps immediate family intervention is needed," Bodewes notes.

Economics: Paying the Bills

The Care Center refers patients to participating doctors on a simple rotation system. But paying physicians' bills is much more complicated. "We have agreements with physicians that they will see our clients, regardless of ability to pay, but with the understanding that we will continue to work with public assistance agencies toward some reimbursement," explains Bodewes. Through grant monies, the Center also has some reimbursement available (at public aid rates) for "girls who are working, perhaps at a fast food establishment, but don't qualify for public aid and can't afford medical care."

Making sure Medicaid dollars are available to prospective mothers and the physicians providing care is a top priority for the Care Center. The organization has a special arrangement with public aid. Clients fill out their applications at the Center, with the help of a counsellor. "We send them all in together on a weekly basis," says Bodewes, "and public aid sets all of our client appointments on one or two afternoons. We know next time our client comes in that she's had an appointment, because we've received a copy of the letter setting the appointment time. What's important is that our clients *know* we know, and that helps them hold up their end of the appointment schedule."



Dr. John Young: "The attitude of Care Center personnel seems to be a mission rather than a job."

The Center's $152,000 budget comes partially from Problem Pregnancy Health Care Act monies, with the balance raised through private contributions, grants and in-kind services. Volunteers come from a variety of professions. Attorneys help with family difficulties and cases of abuse. Local businesses donate products and services for Care Center clients. Hospitals, of course, accept Care Center patients for deliveries, and have helped publicize Center resources. Despite such generosity, "funding continues to be our number one problem," laments Bodewes.

Prenatal Care: Still A Scarce Resource

While the Care Center has certainly eased Springfield's access to prenatal care for the indigent, by no means is the problem totally solved. "There's been some pressure on the Care Center," says Dr. Young. "People ask, 'If the Center is a successful force here, why can't it serve more and more clients?'" Young explains that "the Care Center is not a high volume organization equipped to handle large numbers." Yet, according to Bodewes, when a local hospital recently met with physicians to discuss establishing a clinic, the idea was nixed. Physicians' reactions were that the Care Center was already offering many of the resources a clinic would provide. Consequently, they said they would prefer to work with the Care Center.

Dr. Young echoes that theme. "Most obstetricians agree that the

problem of access to prenatal care is purely financial. There doesn't need to be a new building, a new clinic. There are enough physicians who have time in their office schedules to see more patients, but it's difficult to do that for the current level of public aid reimbursement."

A Counselor's View

Care Center Counselor Joan Reardon has spent eight years listening to and talking through the problems of Springfield's pregnant women. She sees a troubling trend in their stories. "I believe there is a strong link between substance abuse—particularly alcohol—in families and an incidence of unwanted pregnancy. For a long time," she adds, "experts have been on a kick to reduce unwanted pregnancy through making birth control more widely available. That's a theory to which I've never subscribed, because I have seldom found a client who didn't know how to prevent pregnancy." She's still searching for what motivates her clients to become pregnant. "Maybe they want the intimacy," she surmises.

Reardon's personal maxim in helping girls and young adults through their troubled pregnancies: Knowledge doesn't change people, motivation does. She believes "rebellious teens may get some extra purpose in being pregnant that they didn't have before. They get a lot of attention, a regular physician with whom they might begin to bond, a whole tragic love

The Care Center Stands Behind Its Name: One Client's Testimonial

"They're my family. I call them my 'white' family," says Care Center client Marnetta Williams. "They don't make me feel like they do this because it's their job."

She was pregnant and considering adoption for her unborn child when Marnetta moved to Springfield one-and-a-half-years ago. "They didn't try to talk me into it or out of it," she says of Care Center staff, "but they did give me a lot of counseling." She eventually decided to keep her baby.

When Marnetta came to the Care Center, explains the Center's project director Carolyn Bodewes, "she was having a lot of problems in general—just trying to get direction in her life—and also some problems with public aid. She was raising her nephew as well." So the Care Center dove right in, offering Marnetta a full range of counseling and related services to help her get her pregnancy and her life on track. The Center worked with public aid to help remedy problems there. Marnetta was offered nutrition counseling, prenatal classes, and even maternity and infant clothes.



Marnetta Williams, her 19-month-old son Quincy and her nephew Lonnie often return to the Care Center to visit "old friends."

Lining up a physician for Marnetta's regular prenatal care was the Care Center's first priority. "The first time I came in, the Care Center found me a doctor—the best in Springfield!" exclaims Marnetta appreciatively. The Center counselors also accompanied her while she underwent amniocentesis, and were beside her during actual labor and delivery. When her car broke down, they helped her meet her physician's appointment.

"She was really one very, very alone single mother that had no support at all," says Bodewes. That incoming scenario makes Marnetta's subsequent success all the greater victory for Care Center staff. "I can never repay the things they've done for me," sums up Marnetta. "They are called the Care Center, and they stand behind that name one hundred percent." ◀

I believe there is a strong link between substance abuse—particularly alcohol—in families and an incidence of unwanted pregnancy.



Counselor Linda Eck.

story they're playing out." She often asks clients if they've "wished" to be pregnant. "The response to that question can be rather surprising," she says.

How does Reardon approach counseling sessions for these youths? "We begin to talk about what they think their life would be like with a child . . . how a noisy, disruptive two year old would fit in with their school schedule or current weekend plans." Bodewes adds that the counseling is aimed at "getting the girl in touch with the fact that she is, indeed, pregnant and why she opted to become so. In essence it's looking forward to determine what she's going to do with her future, and looking backward to explore how she came to her present situation. By doing so, we hope to break the chain of pregnancy."

Reardon urges physicians to look for trouble signs in young women at risk for problem pregnancy. "Some high risk kids are pretty easy to identify," she adds. "They don't have a clear concept of what to do with their lives. They're doing poorly in school, into dysfunctional behavior and essentially drifting. They're time bombs ready to explode." She advises physicians to not hesitate using counseling referral systems such as the Care Center "as easily as they refer to a dermatologist or surgeon."



Reardon's personal maxim in helping girls and young adults through their troubled pregnancies: Knowledge doesn't change people, motivation does.

Problem Pregnancies: A Social Dilemma

Advises Dr. Young, "Solving the medical part of problem pregnancies is easy, if one can get patients into a physician's office. Fundamentally, teen and other unwanted pregancies are a social problem that doctors are no more capable of solving than other professionals or parents."

And that is exactly where the Care Center's services deliver so much value to the Springfield community. Their personal, full service counseling, grounded in a strong link to prenatal care, has delivered a string of success stories, in addition to healthy babies and mothers.

"They are doing a good, solid job," notes Dr. Simpson, "and I will keep trying to work along with them. The sooner that women, especially teenagers, are seen, the better the outcome. The Care Center gives us a chance to get them on the right track."

Sums up Dr. Young, "The attitude of Care Center personnel seems to be somewhat of a mission rather than a job. There's a strong personal commitment. I feel when they call that I need to respond. They are extending themselves, so how can I say no?" ◀

One Doctor's Formula for Community Outreach

Seizing the Moment



Dr. Luke Burchard, 1988 recipient of the ISMS Physician Public Service Award

Luke L. Burchard, M.D., a board-certified family physician from Mattoon, Illinois, is the Illinois State Medical Society's 1988 Physician Public Service Award winner. His list of community activities defies even a 24-hour-a-day schedule. Number one on his agenda is teaching, cajoling and motivating patients to prevent illness by kicking unhealthy habits like smoking, and latching onto healthful lifestyles.

In this IMJ *profile, Burchard shares his experiences and offers some pointers to colleagues for community outreach efforts that work.*

"Seizing the moment," is how Luke Burchard, M.D., describes every physician's opportunity to educate and motivate patients into self-improvement and healthier lifestyles. He believes strongly that physicians should search for a time and a way of approaching patients on important issues such as diet, alcohol, drug abuse, and smoking. "If they've been waiting two hours because I'm off delivering a baby, that's clearly not the best time. When things are going well, every single patient can be approached on every lifestyle problem. But," he adds, "that's only if we become as skilled at these ideas as we are at inserting Swan-Ganz catheters, reading chest x-rays or applying casts."

Speaking Out: A Job for All Physicians

Burchard considers patient education a skill which is very straightforward if practiced and learned, just like traditional medical invasive procedures. While many physician specialists may shy away from speaking out on public health issues outside their expertise, Burchard urges them to reconsider. "When dealing with the lay public, we're considered the experts. You don't have to be an expert to know a horribly miserable orange from a beautiful orange. And when it comes to smoking and its ill effects, the comparison is just that simple."

Burchard likens the enormity of preventive education challenge to the medical society's 1985 medical malpractice reform campaign. "We had doctors in every city speaking out," he remembers. "And sure enough, consumer awareness rose dramatically. In that same way, we need to mobilize ISMS membership exponentially to get the message out."

Straightforward, nonpatronizing, informal communication with patients on lifestyle issues builds the image of doctors as teachers, not miracle workers, in Burchard's view. "If patients look at us as a learning resource or consultant, their expectations of medicine will be more realistic," he asserts. "They pay us a fee, and we give them good advice on health, not just disease."

Even more important, says Burchard, is the role model physicians can play. And in his view, incorporating a solid preventive medicine example into everyday medical practice is a relatively easy,

non-time consuming way to deliver public health messages. "If a patient walks into a doctor's office and sees a very obese nurse, a secretary who's smoking or a doctor with cigarettes in his pocket, those signals are more influential than all the healthful advice a physician could offer." For instance, Burchard's office waiting room doesn't offer any magazines that carry tobacco advertisements. "I don't want my office cluttered up with reading material that features cigarette promotions right next to health articles," he explains.

Since doctors deal with only a small slice of the community each day—and usually for only a brief time period—Burchard advises colleagues to consider using *all* their resources, from even the parking lot and the waiting area to the exam room, to get the preventive medicine message out. "That's what seizing the moment is all about," he stresses.

A Real Challenge: Reaching Teens and Young Adults

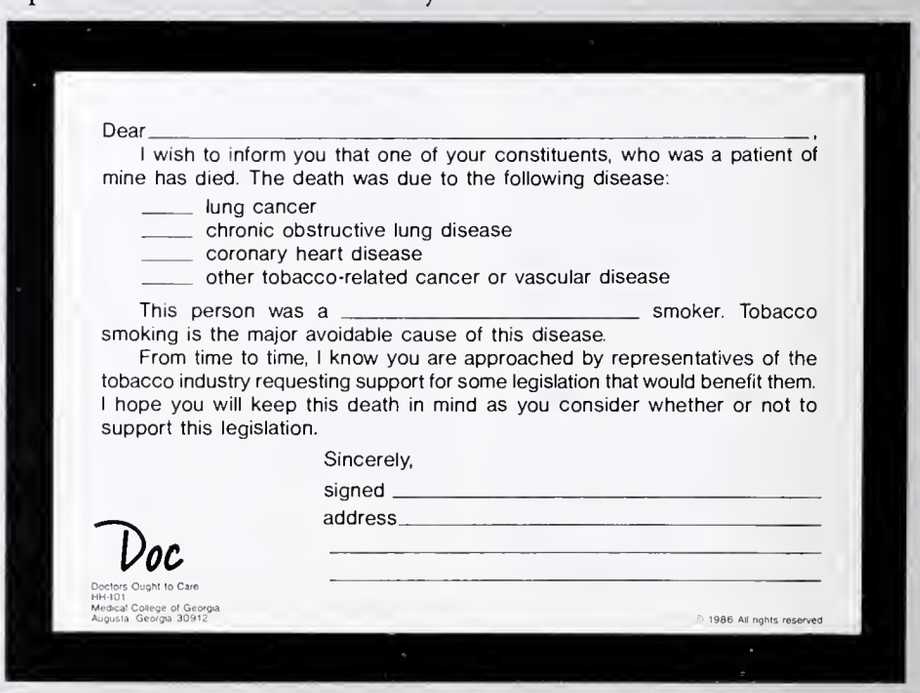
Burchard has geared much of his community service work to reaching adolescents and young adults. The trick to reaching them, he says, is twofold: being "hip" and using peer to peer communication. From poster contests for grade schoolers to "lock-in retreats" for teens, Burchard's strategy, along with the help of community leaders, has produced success. "A little knowledge of what is important to kids comes in handy," he admits. "They're looking for an image, for acceptability, and for some risk taking."

Burchard generally serves as a "consultant" on community youth events, with schools, parents and others doing the day-to-day organizing. "On the weekend retreats for teenagers, we bring in rock bands, have a pizza party, and compete in sporting events. In between all that fun, I provide a couple of

"DOC" Uses Novel Tactics to Battle Tobacco Use

Doctors Ought to Care—"DOC"—is perhaps one of the vanguards of the now-growing anti-smoking movement. Dr. Luke Burchard, as a board member of that group's national organization, has helped set the pace and the tone of DOC's campaign. No one would argue that DOC has been a very visible force alerting the public and public policymakers to the dangers of tobacco. Have its creative, and sometimes revolutionary, tactics proven effective? Or have they gone too far, as some commentators within and outside medicine have suggested?

Dr. Burchard thinks DOC is definitely on the right track—and so much ahead of its time that other organizations are now just beginning to inject DOC-style creativity into anti-smoking education and advocacy. He explains the rationale behind DOC's best-known lobbying tool, the obituary card (shown below). "It's a matter of knowing what makes a legislature tick," he explains. "I testified on many occasions that both cigarettes themselves and second-hand smoke can cause cancer. But when lawmakers receive card



Dear _____,

I wish to inform you that one of your constituents, who was a patient of mine has died. The death was due to the following disease:

_____ lung cancer
_____ chronic obstructive lung disease
_____ coronary heart disease
_____ other tobacco-related cancer or vascular disease

This person was a _____ smoker. Tobacco smoking is the major avoidable cause of this disease.

From time to time, I know you are approached by representatives of the tobacco industry requesting support for some legislation that would benefit them. I hope you will keep this death in mind as you consider whether or not to support this legislation.

Sincerely,

signed _____

address _____

Doc

Doctors Ought to Care
HH-101
Medical College of Georgia
Augusta, Georgia 30912

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(Reprinted with permission of DOC)

'jazzed up' lectures on drug abuse, tobacco, sexual activity—with the message as funny and nonthreatening as possible." A sample of Burchard's slides is shown on page 40.

Using teens who have quit smoking or drinking to deliver the message has maximum impact, in Burchard's view. "A 'Fonzie' type, maybe someone who's a little off-center in their peer group, but who people respect, can teach kids how to give up things," he notes.

Burchard also offers teenagers "open-ended" assistance on problems they may be unable or unwilling to share with their parents. "I always try to check with the parents



Dr. Burchard awaits his cue to go on at one of the many youth presentations he's given.

after card from their own constituency, the impact is geometrically greater." Burchard laments that "it's been a gigantic year for the cards. I can't keep them in stock because of the number of people who are dying from tobacco-related disease. I had five fairly-young people in my own practice die of lung cancer last year."

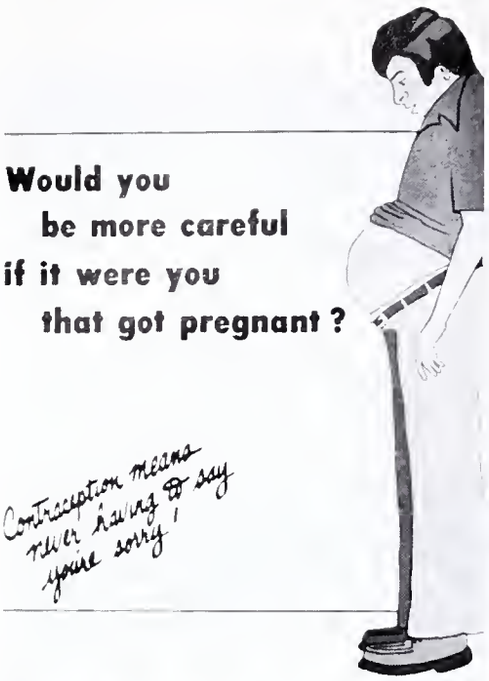
Burchard fills out the cards himself and sends them to federal and state lawmakers. He does not give them to patients' families because "they are usually in a state of shock when the patient dies, even though they know that tobacco was an influence." Our public policymakers need to hear from us "that this person died from cigarettes, plain and simple," he stresses. Burchard also suggests that doctors list smoking on death certificates. "If someone dies of lung cancer, we should identify it as a consequence of smoking."

The Tobacco Institute, notes Burchard, is renowned for citing "first amendment rights" to buttress its pro-cigarette stance. He argues that DOC is just taking a page from the opposition's strategy manual by speaking out forcefully and creatively for the other side. " DOC was the first organization to buy billboard and advertising space, to take out ads on park benches and in national magazines that poke fun at people for smoking," Burchard boasts. "The 'I smoke for smell' parody, the Brooke Shields anti-tobacco spot, the commercial that asked 'Can you spot the cigarette smoker in this ad?' (which showed a fancy cocktail party with one guest in an oxygen tent)—these were DOC ideas," he enumerates.

Founded by family physician Alan Blum in 1977, DOC's offbeat approach is targeted specifically at teens and young adults, either to prevent them from starting the tobacco habit or to kick it before it's fully ingrained. DOC and Burchard have found that humor works best with this finicky audience. Their messages stress that it's " 'in' to kick the 'cigs'!" In addition to techniques noted above, DOC produces a newspaper comic strip, radio shows combining top 40 music and disco with health pointers, sports events like the 'Emphysema Slims' Tennis Championship, posters, and T-shirt giveaways.

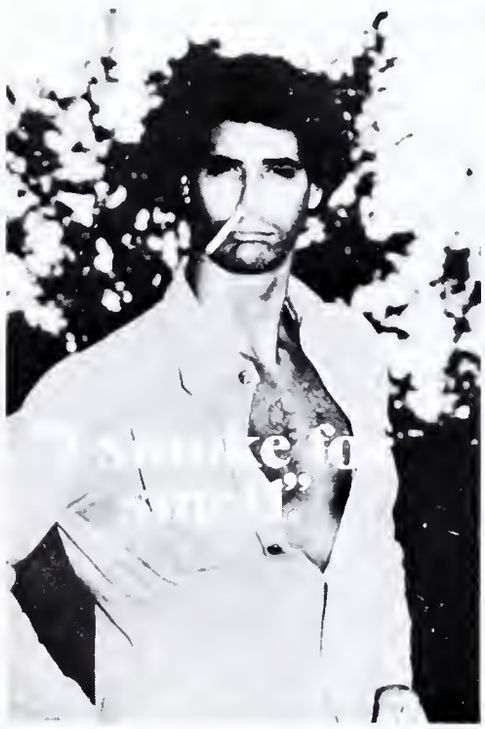
While DOC has not actually spearheaded any liability suits against tobacco companies, they have cheered on others who are pressing for damages. "It's just a matter of time before liability is proven," portended Burchard, who was interviewed for this story just two weeks prior to a jury awarding $400,000 damages to the husband of a late two pack-a-day smoker. Burchard defends DOC's enthusiasm about the explosion of tobacco litigation. "Why is tobacco the only product escaping liability law?" he queries. "If one person dies in a defective car, half a million autos can be recalled. If a person gets tomaine from vichyssoise, Ralph Nader could close the whole company down! But there are more dangerous chemicals in tobacco than perhaps any product consumed by today's public."

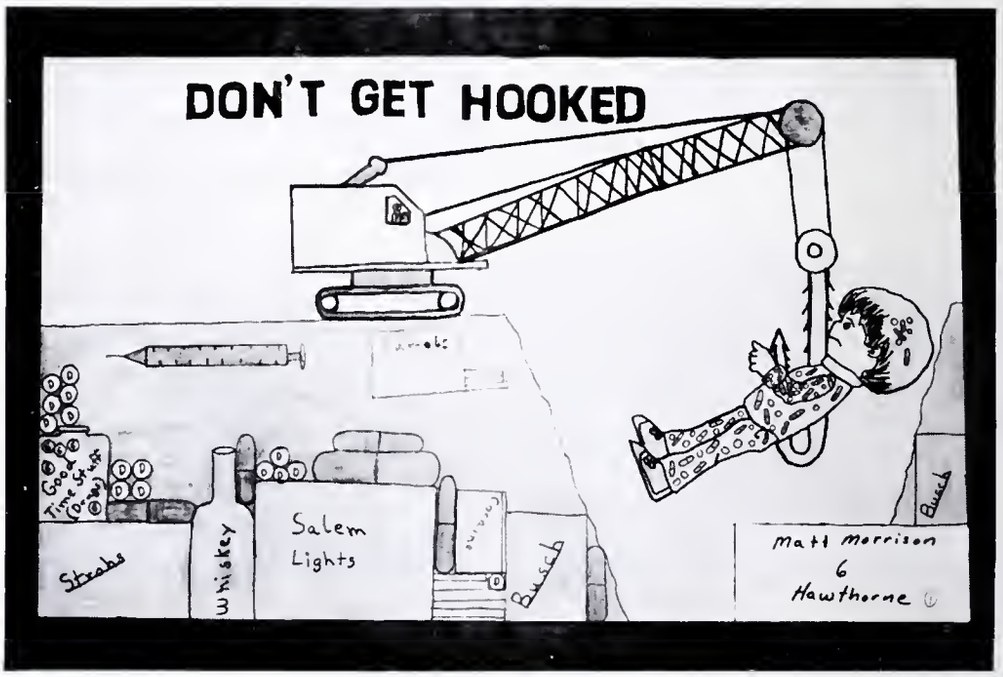
DOC has developed an involvement plan for physician community outreach efforts, which is now integrated into the residency curriculum of the Society of Teachers of Family Medicine. For further information, contact Dr. Jim Richards, DOC, c/o the Medical College of Georgia, Building HH101, Augusta, Georgia 30912. ◀



These are samples of slides Dr. Burchard uses to get his message across to Illinois teens. Also included (center) is a winner from the local annual student poster contest. (Reprinted with permission.)







Doctors should never try to pull anything over on a teenager. If they think you're "half baked," they'll think you really don't care.







first, or at least let them know the offer exists," he says, "by telling them I've advised my teenage patient that I'll answer any and all health-related questions. I'm certainly not trying to deal behind anyone's back. And the bottom line is that the kids know they can call me," he adds.

Burchard's rationale is that kids have "a lot of personal questions they just can't ask their parents." Without a nonthreatening adult resource, they often turn to friends for advice—where information is anecdotal or outright wrong. But Burchard warns that doctors should never try to pull anything over on a teenager. "If they think you're 'half-baked,' they'll think you really don't care. They know when you're sincere."

Help Wanted: Advocate of Illinois' Clean Indoor Air Act Needs Vocal Support

The Illinois Clean Indoor Air Act once again seems unlikely to gain legislative approval this year, as *IMJ* goes to press. But prospects for its future success are looking somewhat brighter, thanks to a recent series of anti-smoking victories, including passage of a similar bill by Chicago's city council that bans smoking in public places.

ISMS' 1988 Public Service Award winner Luke Burchard, M.D., has been in on the state level anti-smoking battle from the start. As former chairman of the Illinois Interagency Council on Smoking and Disease, Burchard has become a familiar face in the state capital, talking to policymakers about the dangers of second-hand smoke. So far, his and many others' efforts have been to no avail, since the bill failed by just one vote in committee this year. The medical society has actively supported passage of such legislation.

Why has success so far eluded the clean air coalition? Says Burchard, "Many legislators, from leadership right on down, have very strong ties with the tobacco lobby. The more money you have, the bigger the guns you can hire to lobby against the bill," he notes. "They have millions, and they hire 'Rambos.' "

'Rambos,' as defined by Burchard, are very powerful lobbyists who advocate a variety of other business issues and are often ex-legislators themselves. To date, they seem to have successfully buckled the tide of public opinion which overwhelmingly supports passage of the Act. Burchard cites a nationwide Roper survey commissioned by the tobacco industry itself showing that both smokers and nonsmokers favor restrictions in public places.

He also recalls testifying a few years ago before a state legislative committee considering the bill. "Several committee members were smoking throughout my testimony, and one asked how such legislation would be enforced in a committee room like this. On the door to the room was posted a Springfield city ordinance prohibiting smoking. I told them, 'You're already in clear violation of the law.' That was the end of that hearing."

Burchard believes that passing the Indoor Clean Air Act would send a strong signal that public buildings will not be a forum for the onset of smoking habits. He compares it to the Interagency Council's petitions to both Mayors Jane Byrne and Harold Washington that they not smoke in public, "especially since blacks and women are the groups still taking up smoking at such an alarming rate. Policymakers should be role models for adults and youth who look up to them," he asserts.

Burchard urges doctors to "keep up the pressure on local lawmakers" for passage of this serious legislation. "We must turn the situation around," he emphasizes. "Being right, I've learned, has little to do with getting this bill passed in Springfield, and if that means 'taking the issue to the streets' to show politicians how violently opposed America is to tobacco, then so be it." ◀



This is David Jr. He's a smoker. But not by choice. You see, when David's parents smoke around him, he's smoking too.

And babies who breathe tobacco smoke are twice as likely to have chronic or recurring respiratory illnesses, according to both the 1986 U.S. Surgeon General's Report on Passive Smoking and a 1986 report issued by the National Research Council's Committee on Passive Smoking.

In America, 42% of all children under one year old live with at least one smoker. You can change that.

Warn your patients about the danger. And until you're able to help them quit, recommend that they don't smoke around their baby.

TELL THEM NOT TO SMOKE. THERE'S A BABY IN THE HOUSE.

U.S. Department of Health & Human Services.

Training for Preventive Medicine

"Broadening communication skills is something doctors should be taught from medical school through residency, right into practice," Burchard advocates. He's talking not only about writing and public speaking capabilities, but also about serving as a community catalyst for action. If a doctor shows an interest in health education, Burchard believes, "other community leaders jump on the bandwagon."

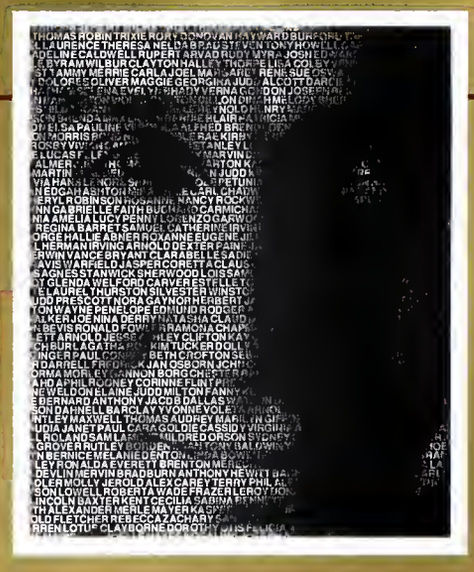
He remembers starting to produce simple programs during his own residency several years ago. "We developed some movies, slide shows and posters for our own clinic patients. They were very basic, on topics like nutrition and prenatal care. We thought it 'radical' at the time, but now it would be considered 'not enough.' Looking back," he says, "these things should have been part and parcel of our residency training. But we were so busy concentrating on biochemistry that we forgot how to approach patient education."

Doctors in training need to be groomed, according to Burchard, to include a lifestyle survey in every patient encounter. It's not only a matter of giving something back to the community, it's one of competition, he believes. "Preventive medicine is contemporary medicine, and patients are disappointed if their doctor doesn't help them accomplish an image of health."

The bottom line is that allied health practitioners are quickly filling the void, says Burchard. "If we're not preventive specialists, it will be the chiropractors, naturopaths, nurse midwives, and others," he predicts. "These days chiropractors put patients on diets. They screen for cholesterol, and write exercise prescriptions. We in medicine can't let ourselves be beaten to the punch." ◀

EXPECT YOUR NEXT PATIENT ON INDERAL® LA TO...

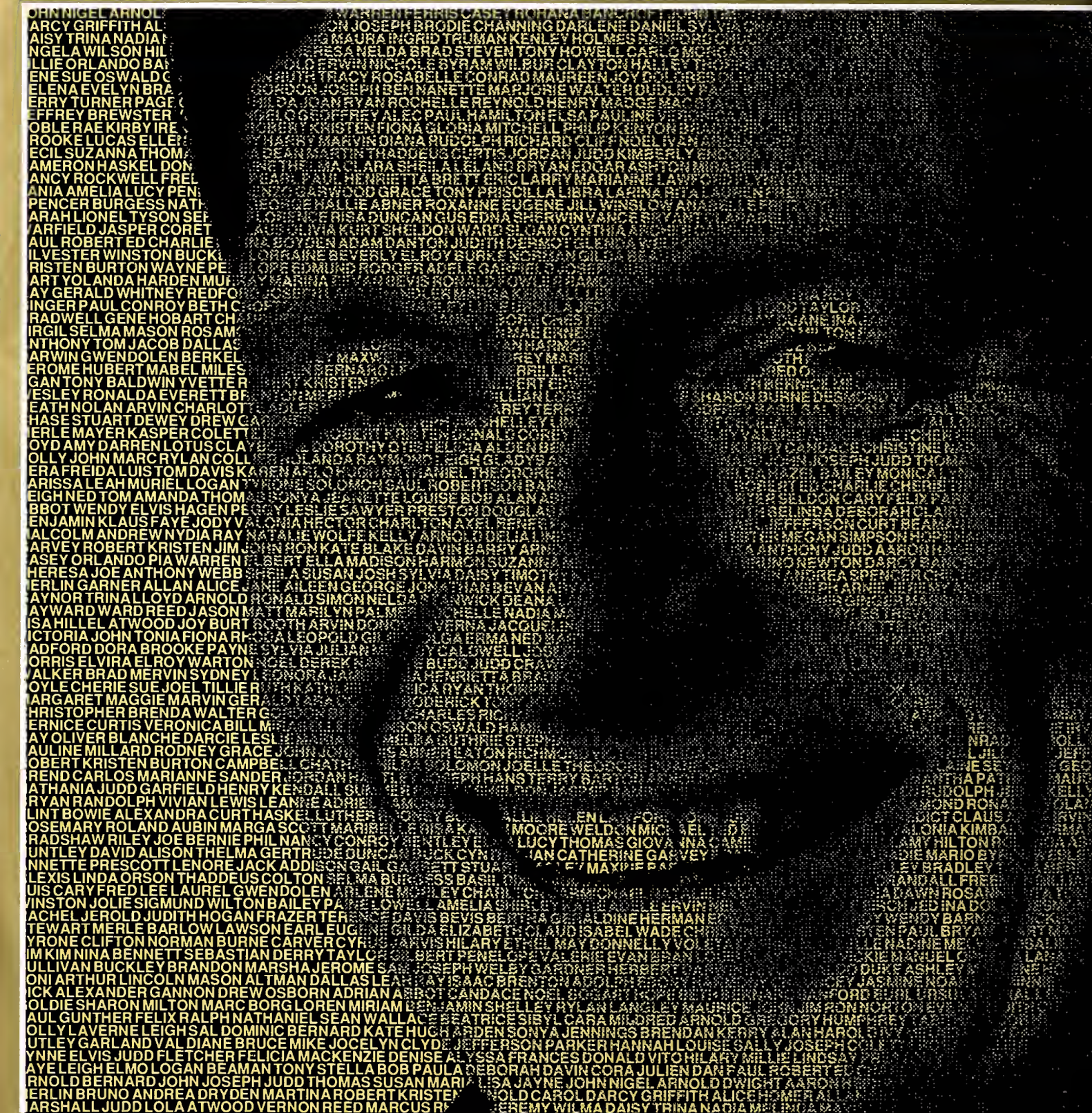
(PROPRANOLOL HCl)
LONG ACTING CAPSULES 60, 80, 120, 160 mg



Please see brief summary of prescribing information.

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MILL



ON



...like the more than one million patients who have received INDERAL® LA.

In a recent survey, 4,120 participating physicians gave us their views[1] on INDERAL LA in the treatment of hypertension, angina and migraine.

INDERAL LA is their preferred beta blocker

...of the nearly three out of four physicians responding to the questionnaire, an impressive 97% rated INDERAL LA good to excellent for overall performance. Virtually all cited efficacy, tolerability, long-term cardiovascular protection and once-daily convenience as important factors in their choosing to prescribe INDERAL LA.

INDERAL LA promotes patient compliance

...Virtually every responding physician rated patient satisfaction with INDERAL LA to be as good as, or better than, other beta blockers.

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree and bronchial asthma.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES
60, 80, 120, 160 mg

The one you know best keeps looking better

Please see next page for brief summary of prescribing information.



ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES
60, 80, 120, 160 mg

The one you know best keeps looking better



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefo abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroi ism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 a reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a dema pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impair hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hyperte sive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be to that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart diseas elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as rese pine should be closely observed if INDERAL (propranolol HCl) is administered. The adde catecholamine-blocking action may produce an excessive reduction of resting sympathet nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attack or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calciur channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardi contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of beta blocker and verapamil has resulted in serious adverse reactions, especially in patients wi severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly wi propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasir blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in anima have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in bo rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-i duced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reprodu tive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in anim studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be use during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised whe INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rare required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotensio paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud typ

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitud weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hall cinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time an place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased perfo mance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dream appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constip tion, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching an sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, an Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skil serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associate with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in sustained-release capsule for administration once daily. If patients are switched from INDERA Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERA INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessar especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL L once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg onc daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage i 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed f full hypertensive response to a given dosage is variable and may range from a few days to sever weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once dail dosage should be gradually increased at three- to seven-day intervals until optimal response obtained. Although individual patients may respond at any dosage level, the average optimal dosag appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 m per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (se WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once dail The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually t achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to s weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may b advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited t permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:
1. Data on file, Ayerst Laboratories.

D7295/188

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An Illinois Perspective

AMA Explores Alternatives to the Court System

Early this year, a new way of resolving medical liability disputes was proposed by the American Medical Association and 32 national medical specialty societies. Called the Medical Liability Project, it would be a fault-based administrative system, patterned much like the present state-run worker's compensation system and would be administered by substantially expanded state medical boards or other state agencies. This approach as envisioned would ultimately supplant the existing court jury system, but presently is being offered only as a promising alternative to the costly tort system.

Alfred J. Clementi, M.D., was one of eight physicians nationally chosen by the AMA to serve on a Professional Liability Advisory Panel. Dr. Clementi, a board certified surgeon, has been active in the conception and implementation of the society's professional liability initiative as well as last year's rewrite of the Medical Practice Act. He is former chairman of ISMS' Board of Trustees and chairman of the ISMIS Loss Prevention Committee.

We asked Dr. Clementi to share his personal views of the proposed Medical Liability Project.



IMJ: ***Let's begin by talking about the fault-based administrative system, a proposed alternative to the civil justice system for resolving medical liability disputes. What does that mean?***

Dr. Clementi: A cursory review of liability and malpractice problems in the state makes it clear that a number of problems need to be addressed. We have made major tort reforms and changes in the areas of liability and loss. But many physicians brought to trial continue to lose cases, not because of their negligence or bad care, but because of two misperceptions. First, we see a high level of expectation on the part of those receiving the care and, second, we see a general public feeling that all outcomes should be good, and if a bad outcome occurs someone should pay.

These misperceptions are often pertinent in the patient's response to what would be considered normal complications. About five percent of patients who undergo carotid artery surgery are expected to develop stroke or stroke-like symptoms. That is a complication of surgery, but it is an *expected* complication. In removing the blockage, one will occasionally loosen debris, which could cause injury. That can be expected, and the physician should not be penalized for the damage when it occurs. But the patient who went to surgery without any symptoms and has a stroke afterward says, "You must have done something wrong." And unfortunately, the jury system looks at the outcome, and decides there should be some compensation. There's a real problem here. If we begin to compensate people for what is an expected, normal process, then we will soon be paying for all social ills. Although as professionals, we can attempt to educate

Taking Malpractice Torts Out of the Courts

"We have worked for over a year with a unique coalition of lawyers, physicians and public policy experts—inside and outside of organized medicine—to design what is above all a fair system. . . . We believe that more patients injured by medical negligence will be compensated under this plan, but that fewer dollars will be spent on meritless claims and unnecessary transaction costs." This was the assessment of AMA senior official James S. Todd, M.D., as he launched the proposal for a fault-based administrative system to resolve medical malpractice litigation. He was accompanied by 32 national medical specialty organizations which co-authored the plan.

The proposed system has three parts:

- a claims resolution function;
- a credentialing and disciplinary process;
- a codification of the legal elements of medical liability.

Administered by a state board or agency whose members are appointed by the Governor, the plan would allow for physician board membership, but not as a majority.

The Claim Resolution Process

Patient complaints would be filed with the administrative agency, and an initial screening performed by experienced examiners. Parties would be interviewed, medical records examined and staff lawyers provided at no cost to any claimant requesting them. The plan's authors believe that most claims would be resolved at this low level of involvement. If unresolved, however, the claim would progress to a full-fledged hearing examiner. That examiner's decision would, in turn, be subject to review by the full agency's board. The plan also gives the board discretion to award fees and costs incurred in the appeal against the losing party.

Credentialing and Discipline

All settlements and awards would be reported to that same agency's investigative branch to determine if substandard care or a pattern of fraud or incompetence exists. Mandatory physician performance credentialing would occur, with below-standard performance reported to the agency. Insurance cancellations and nonrenewals for reasons of incompetence would also be reported.

These provisions are similar to Illinois' mandatory reporting law, supported by the Illinois State Medical Society, which took effect several years ago.

Legal Elements of Liability

The plan proposes abolition of the current standard of care based on locality and custom, substituting one that focuses on a "range of reasonableness" for a prudent and competent doctor in similar circumstances.

Contributory negligence, allowing for patient recovery even if the doctor was less than 50 percent at fault, would govern. Noneconomic damages would be capped, at an amount tied to the state's average annual wage. The plan would abolish the joint and several liability rule, and periodic payments would be mandated for large future damage awards.

For further information on the AMA's fault-based administrative system, contact the Illinois State Medical Society, or the American Medical Association's Office of the General Counsel at (312) 645-4615. ◀

the general public about what liability is, we obviously can't educate everybody. The problem in our present system is that when a physician is brought to trial, the information is presented by an attorney to a judge and jury, none of whom have medical experience. Any medical experience is supplied by experts testifying as advocates for one party or the other, not true experts.

We feel that a new system is needed in order to correct this problem. The AMA has proposed an approach to medical malpractice which includes what is referred to as a "fault-based" administrative system. Fault-based is not a no-fault system—this is not an offer to pay for any loss. It is a system which requires that the plaintiff prove liability on the part of the physician in order to get compensation. It is an "administrative" model in that it is not before a jury, but rather before, first, a reviewing officer and subsequently, a panel, which makes a judgment. Under this proposal, anyone who has a claim would—instead of going to a lawyer and subsequently to the courtroom—initially go to a reviewing department of the state, where the complaint would be reviewed by experienced claim reviewers at no cost to determine if there are grounds for judgment. If grounds exist, the process would continue from there.



IMJ: *The AMA has said that a fault-based administrative system may result in more initial claims. How will this save money?*

Dr. Clementi: Two things will happen. One, it will be easier to file a claim. The individual will have a very early appraisal of his claim's validity. He can bring a claim much more easily, get information and get resolution without ever risking any money. In fact it will be much easier to bring a claim than it is now. But overall, it will be far less expensive. Non-meritorious claims will be knocked out much earlier. Claims which get to court will be more clearly based on negligence rather than bad outcomes.

IMJ: *The claims resolution process provides attorneys at no cost. What's the rationale behind that?*

Dr. Clementi: We would save attorney fees, so more money would ultimately go to the patient. And "small" cases, which might not be attractive to counsel, would have a hearing.

IMJ: *Since a lot of those small claims probably aren't getting into the court system now, will there be a big increase in payouts on minor injuries?*

Dr. Clementi: There may be some increase, but I don't think that's unreasonable if it is appropriate. I think that doctors are willing to say that the size of the claim should not be the factor, it should be whether or not there's merit to the case. We believe that good doctors should be rewarded and bad doctors should be punished.

IMJ: *What about appeals? Isn't there a provision stating that if you don't like the decision of the review officer and the review panel, you can go back to the court system?*

Dr. Clementi: No. This replaces the court system completely. First, a hearing officer makes a judgment. Then, a three-member panel reviews all information if it goes forward to that status. There may be an appeal of that three member panel, but that is to the entire review board, which is made up of seven members. In effect, the three member panel makes the decision.

If we begin to compensate people for what is an expected, normal process, then we will soon be paying for all social ills.

IMJ: *How would the agency work that would develop and operate the system? How would it be funded? Is this another bureaucracy?*

Dr. Clementi: No question that there are problems with a bureaucracy. The agency would be made up, first of all, of experienced lay people. Perhaps they'd come from the law enforcement area. They may be people who have worked with claims and have developed expertise in this area. This is in contrast to a jury of inexperienced people

who have come to the courtroom to make a judgment on a malpractice case, and who may feel sorry for the individual who's been injured in the process. We're looking for individuals who would make informed evaluations and fair judgments.

The funding would come from several sources. First of all, it would come certainly from doctors and hospitals in the form of a fee or charge. Private financing may also be a possibility. Insurance company and general funds would also be involved.

IMJ: *So all the doctors would pay for it, not just the ones who were involved in the system?*

Dr. Clementi: Exactly. The cost would be included as part of your license fee. But more funding is needed than that. The hospitals would also be involved in this process, and should be equally taxed. That could be done on a per capita basis. Insurance companies in the liability area also would contribute.

The funding would certainly be more than what we presently pay for our discipline and licensing boards, but it would have to be a separate system handling only malpractice. An advantage of having this information funneled into a state administrative board is that information is easily available for evaluation of physicians. It has been said that two percent of the doctors account for 36 percent of the liability claims. If this is the case, those individuals should not simply be denied insurance, they should be disciplined. We presently, have a discipline law which does address that, but much later in the system. My point is, this proposed system could become a more efficient mechanism for getting the bad doctors out of the system

IMJ: *But we've already got a mandatory reporting law.*

Dr. Clementi: The new system, with its running evaluation process, would improve the identification and follow-up of bad doctors.

IMJ: *What major benefits would this alternative offer in Illinois?*

Dr. Clementi: First of all, it would be easier for patients to find out whether or not they had a claim. Secondly, it would accelerate resolution very early in the process. And we think that the arbitrary large awards, especially in the area of non-economic loss, would be greatly reduced.

Benefits to the doctors are speed, quick resolution, fairness, and reasonable awards. Patient advantages are quick resolution, avoidance of large attorney fees, and the receipt of the entire award.

IMJ: *What about drawbacks?*

Dr. Clementi: Well, I think the major difficulty is the constitutionality of the proposal. And I think in fact that there is some question as to whether the state of Illinois would say that it is in fact unconstitutional. We all know the Supreme Court's decisions are different in different states, and what is acceptable as an absolute cap on awards in one state is considered unconstitutional in another state, even though, in effect, the basic law is written similarly in both states. We would hope that if other states were to adopt this type of system and prove it to be good for the public and good for maintaining the quality of medical practice, this type of system would be considered constitutional and put into effect in Illinois.

IMJ: *In Illinois, we currently have an administrative worker's compensation system, but that's no fault. Is that a trade-off not found in this system?*

Dr. Clementi: The no-fault concept of compensation says that the employer is willing to pay for any injury that occurs on the premises. In that particular trade-off, the amount of the award is lowered. We're not asking that the amounts be lessened, we're saying the award should be reasonable and fair. We can all think of examples of individuals who lost cases that should not have been lost. Again, it had to do with the complexity and difficulty of the case, not on its basic merit.

Fault-based is not a no-fault system—this is not an offer to pay for any loss. It is a system which requires that the plaintiff prove liability on the part of the physician in order to get compensation.

IMJ: *How will compensation be awarded for pain and suffering?*

Dr. Clementi: There would be a cap on pain and suffering, but we're talking about a larger cap than what we were talking about originally. We think it would be reasonable to have a higher cap only in so far as there needs to be some upper limit of reasonableness. This system cannot tolerate carte blanche awards.

IMJ: *There's some change in the standards of liability too, isn't there?*

Dr. Clementi: In deciding malpractice claims and awards, the state agency would adopt some of the

nost popular features of recent nalpractice reform. Under the AMA's proposal, doctors would no onger have to show they meet 'generally accepted standards of :are." Instead, a doctor would have o prove he acted as a prudent and :ompetent practitioner. In making uch a judgment, the state would :onsider the expertise of a doctor, he state of medical knowledge, and he doctor's access to transporta- ion and communication facilities.

IMJ: *Contributory negligence would change, too, under this sys- em. Even if the physician is less han fifty percent at fault, there would still be payout. What's the ationale behind that?*

Dr. Clementi: It's very similar to what we have in Illinois: even hough we think there are some problems associated with the less han fifty percent rule, there are ome instances when a doctor hould have reasonably informed he patient about a particular pro- ess. Even though it may end up osting as much, it's going to be a air system.

IMJ: *So we're really taking a leap nto the unknown, but from an infair system to one that hopeful- y is based on fairness. Would this work in small states as well as big tates?*

Dr. Clementi: The only difference nay have to do with the constitu- ionality. But there's no reason why ny state couldn't have this system.

IMJ: *Consumer groups have said hat with legislators changing so often, they can only count on the court system to defend their hard- won rights. How would you con- vince patients and consumers to give up the tort system?*

Dr. Clementi: Three things are nvolved. One is the cost. Doctors re paying, but at the expense of he patient. Defensive medicine is being encouraged, resulting in unnecessary testing and longer hospital stays. The second thing is the availability of good medical care. Doctors are not continuing to practice medicine; less people are going into such high risk specialties as OB/GYN. Third, patients can collect on small claims with this system and retain 100% of awards on large claims. Letting go of the tort system can be a difficult thing because they know what they can and cannot expect in that system. But I think they also are aware that with a good defense lawyer on the other side they could lose a case they should have won. The system should be based on fairness, not on who's got the better lawyer.

. . . They also are aware that with a good defense lawyer on the other side they could lose a case they should have won. The system should be based on fairness, not on who's got the better lawyer.



IMJ: *So doctors won't necessarily win more cases under this system?*

Dr. Clementi: No. We are trying to initiate a system of fairness. And I believe this really is a fairer system.

IMJ: *Describe the group within the AMA that developed this idea. How did you go about it?*

Dr. Clementi: The advisory panel for the Task Force on Medical Liability at the AMA was a group of eight members from around the country. The Task Force on Liability is actually AMA staff. They were supported financially by 32 national specialty society organizations, with contributions totalling over half-a-million dollars.

Basically we were looking for something that could replace the court system. Tort reform has potential, but many states such as California, have probably accomplished all they are going to accomplish in the way of significant reform and they still do not have a totally fair system. This administrative system is one alternative. There may be others.

IMJ: *Have any states decided whether or not to push for this?*

Dr. Clementi: At this point, some states are considering the process. The AMA would like to see it evaluated and tested in an area where it has the greatest potential for success. This is a good faith effort. Time will tell whether it meets with public approval and is supported by the courts. ◀

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

August

Obstetrics/Gynecology

Gynecologic Surgical Techniques
For: Obstetricians and Gynecologists. Lecture, July 25-27, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** $515. **Reg. Limit:** 75. **Credit:** Category 1: 21 hours; ACOG Formal Learning: 20 cognates. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Surgery

Specialty Review in Surgical Critical Care
For: Surgeons and Critical Care Specialists. Lecture, Aug. 15-19, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** None. **Credit:** Category 1: 35 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Specialty Review in General Surgery, Part I
For: General and specializing surgeons. Lecture, Aug. 22-Sept. 2, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** $880. **Reg. Limit:** None. **Credit:** Category 1: 94 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Surgery, Ophthalmology, Dermatology

Laser Use and Safety Issues
For: Physicians and other health professionals. Conference, August 25-26, Madison, WI. **Sponsor:** University of Wisconsin-Madison, Continuing Medical Education, 2715 Marshall Court, Madison, WI 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1: 10 hours; AOA Category 2-D: 10 hours; University of Wisconsin CEU: 10 hours. **Contact:** Cathy Means, Program Coordinator. **Phone:** (608) 263-6637.

September

Anesthesiology

The Use and Interpretation of Monitoring and New Technologies
For: Anesthesiologists. Symposium, Sept. 9-11, Chicago, IL. **Sponsor:** University of Chicago School of Medicine, Center for CME, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** $275. **Reg. Limit:** 250. **Credit:** Category 1: 15.5 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Cardiology

Advances in Echocardiology
For: Cardiologists. Symposium, Sept. 8-9, Chicago, IL. **Sponsor:** University of Chicago School of Medicine, Center for CME, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** $100. **Reg. Limit:** 200. **Credit:** Category 1: 11 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Dermatology

Specialty Review in Dermatology
For: Dermatologists. Lecture, Sept. 19-24, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 39 hours; AAD Category 1: 39 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Family Practice, Otolaryngology

TMJ Disease: A Multidisciplinary Problem
For: Physicians and other interested professionals. Conference, September 16-17, Madison, WI. **Sponsor:** UW-Madison, CME, Dept. of Surgery, Division of Plastic and Reconstructive Surgery, School of Medicine, 2715 Marshall Court, Madison, WI 53705. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 9 hours; UW CME: 9 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

General Practice

41st Annual Clinical Refresher Course
For: General and Family Practitioners. Lectures and workshops, Sept. 28-Oct. 1, Oak Brook, IL. **Sponsor:** Chicago College of Osteopathic Medicine, 5200 S. Ellis Avenue, Chicago, IL 60615. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1: 21-27 hours. **Contact:** Marie E. Kowalsky. **Phone:** (312) 947-4606.

Internal Medicine

Specialty Review in Pulmonary Disease
For: Internists and pulmonologists. Lecture, Sept. 26-30, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. Credit: Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Specialty Review in Infectious Disease
For: Internists and infectious disease specialists. Lecture, Sept. 26-30, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Specialty Review in Hematology
For: Hematologists, oncologists, and internists. Lecture, Sept. 26-30, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. Phone: (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Ophthalmology

Cornea, Cataract and Lasers '88
For: Ophthalmologists. Symposium, Sept. 17, Chicago, IL. **Sponsor:** University of Chicago School of Medicine, Center for CME, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** TBA. **Reg. Limit:** 200. **Credit:** Category 1: TBA. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Ophthalmology, Neurology, Radiology

Clinical Neuro-Ophthalmology Symposium
For: Ophthalmologists, neurologists, and radiologists. Symposium, Sept. 9-10, The Wisconsin Center, Madison, WI. **Sponsor:** UW-Madison, CME and the Depts. of Ophthalmology and Neurology, School of Medicine, UW-Madison, 2715 Marshall Court, Madison, WI 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; UW CEH's: 7 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Psychiatry

The Psychiatric Interview
For: Psychiatrists. Course, Sept. 23-25, Chicago, IL. **Sponsor:** University of Chicago School of Medicine, Center for CME, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** 200. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

October

Cardiology

Balloon Application in Cardiovascular Medicine
For: Cardiologists, Internists, Family Practitioners, Physicians-in-Training and Nurses. October 29, Peoria, Illinois. **Sponsor:** The Methodist Medical Center of Illinois, 221 N.E. Glen Oak Avenue, Peoria, IL 61636. **Fee:** $40. **Reg. Limit:** None. **Credit:** Category 1: 5 hours; AAFP Prescribed: TBD. **Contact:** Jerelyn Blackburn. **Phone:** (309) 672-4895.

Pulmonary Diseases

Second Annual Weekend Refresher in Pulmonary Diseases
For: Primary Care Physicians. Practical review with lectures and case oriented discussions, October 14-15, Galena, IL. **Sponsor:** The University of Illinois College of Medicine at Chicago, Dept. of Medicine, Section of Respiratory and Critical Care Medicine, 912 S. Wood Street, (m/c 607), Chicago, IL 60612. **Fee:** $195. **Reg. Limit:** 120. **Credit:** Category 1: 10 hours applied for; AAFP Prescribed: 10 hours applied for. **Contact:** Sue Talbert. **Phone:** (312) 996-4631.

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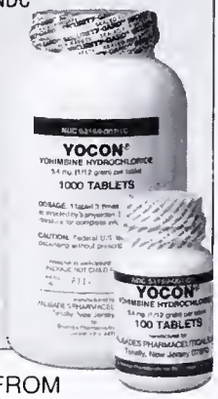
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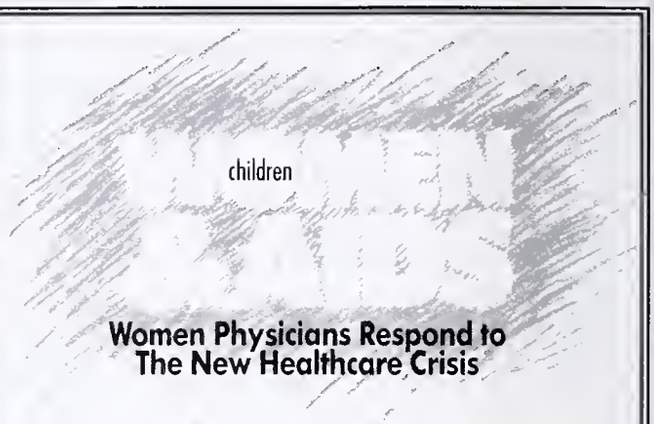
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(continued from page 6)

Diagnosis: Secondary Chondrosarcoma

The cortical destruction indicates an aggressive bone lesion and could be due to osteomyelitis or a malignant bone neoplasm. Osteomyelitis could result in dense sequestra in the infected bone, but the irregular medullary densities in this case are more characteristic of cartilage matrix calcifications, which occur in neoplasms derived from cartilage. A Ewing's sarcoma rarely occurs in older age groups and does not produce this type of calcification. This picture best fits a chondrosarcoma. This patient's lesion is felt to have complicated a pre-existing enchondroma and is, therefore, a secondary chondrosarcoma.

Chondrosarcoma is defined as a malignant tumor in which cartilage, but not bone, is formed by a sarcomatous stroma. Chondrosarcoma is the third most common primary malignancy of bone, following multiple myeloma and osteosarcoma. A primary chondrosarcoma is one that arises *de novo* in bone. Secondary chondrosarcoma develops in pre-existing benign cartilage tumors or other non-malignant bone disease. There are several conditions that may be complicated by chondrosarcoma.

Osteochondroma

Solitary osteochondromas are the most common benign bone tumors, but they are rarely associated with malignant degeneration. True incidence is unknown, but is probably a fraction of 1%.

Hereditary multiple exostosis (diaphysial aclasis) is inherited in an autosomal dominant pattern. Malignant degeneration of osteochondromas in these patients is much more frequent than in solitary osteochondromas. The literature reveals striking variation in the incidence of secondary chondrosarcoma. A complete pedigree of 36 patients had only one case of chondrosarcoma,[1] while a series of 272 cases had a 10% incidence.[2] Others believe that variable penetrance is an important factor and that in different pedigrees the incidence can range from 3%-25%.[3]

Enchondroma

Solitary enchondromas have more malignant potential than the solitary osteochondromas. Enchondromas develop within the medullary portion of bones. Enchondromas in the hands and feet rarely become malignant.[4] Those in the long tubular bones more often become malignant, especially in more proximal areas.

Multiple enchondromatosis (Ollier's disease) is a sporadic, non-hereditary cartilage dysplasia of bone representing an inborn anomaly of osseous development. The reported incidence of secondary chondrosarcoma ranges from 10% in a series of 37 to 30% in one with 55.[5] Maffucci's syndrome is similar to Ollier's disease, except that it has the additional feature of soft tissue hemangiomas. Authors who reported seven patients with four chondrosarcomas believe the actual incidence approaches 100%.[6] A composite series of 129 cases had 23% chondrosarcomas.[7]

Other Conditions

Other conditions are rarely associated with chondrosarcoma. Fibrous dysplasia, especially the polyostotic form, has been complicated by chondrosarcoma. Paget's disease is usually thought to result in osteosarcoma but chondrosarcoma rarely occurs. Radiation-induced sarcomas may occur in benign lesions or normal bone that has been included in the radiation port. Although most of these are osteosarcomas or fibrosarcomas, chondrosarcomas do occur. The time interval between radiation therapy and development of a sarcoma has varied from 4-30 years.[8] Chondrosarcomas have rarely developed in synovial chondromatosis,[6] chondroblastomas, chondromyxoid fibromas, periosteal chondromas, bone infarcts, and unicameral bone cysts.[9]

Clinical

Patients with secondary chondrosarcoma most often present with a painless and enlarging mass; less than one third present with pain. Persistent pain in a known enchondroma, osteochondroma, or other known benign bone lesion should always raise the suspicion of malignant degeneration. Growth of a lesion after the epiphyses have closed is also suspicious for development of malignancy. Interestingly, some patients with chondrosarcoma exhibit a diabetic glucose tolerance response,[9] while others have been found to have high levels of chorionic gonadotropin.[10]

Radiology

The prerequisite for diagnosis of a secondary chondrosarcoma is a previously benign bone disorder, recognized pathologically or radiologically. Signs of transformed enchondromas include poor margination, cortical destruction or thickening, periosteal new bone formation and soft tissue extension. At an early stage it may not be possible to differentiate a benign enchondroma from a chondrosarcoma based on radiographs. Change in appearance compared to old radiographs is important. Location of a large lesion in the proximal skeleton should also arouse the suspicion of malignancy.

Early signs of malignancy in osteochondromas include poor definition of the margin of the lesion, cortical destruction or thickening, and a large soft tissue mass with calcification. An early chondrosarcoma may be indistinguishable from a benign osteochondroma. An adult with a lesion associated with persistent pain should continue to be suspect for malignant degeneration, even if the radiographic appearance is benign. An unusually thick cartilage cap on computed tomography or magnetic resonance is also suspicious of malignancy.[11] In addition, CT and MR are valuable for assessing tumor extent.

Treatment

Treatment depends on the histologic grade and size of the neoplasm. Recently, cryosurgery has been advocated for medium, and especially, for low grade sarcomas. Radical surgery with wide margins has been the treatment of choice, particularly for highly malignant tumors. Chondrosarcomas are generally considered to be radioresistant. Chemotherapy has very limited value.[9]

Prognosis depends on size and grade. Overall, five year survival is about 50%. High grade lesions metastasize early and usually to the lung. Low grade lesions infrequently metastasize and most of their damage is local.[9]

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Exchange Insights

July, 1988

ON MALPRACTICE PREVENTION

The Board of Governors of the Illinois State Medical Inter-Insurance Exchange presents "Exchange Insights on Malpractice Prevention" as a service to Illinois State Medical Society members and Exchange policyholders. This monthly feature is designed to educate physicians on those areas in their practice which have the potential for causing claims, and to offer possible ways to minimize risks. **Exchange Insights** *may be removed and kept with your other important Exchange professional liability information.*

The Risks of Keeping Incomplete Medical Records

This month we take a look at a medical case which demonstrates what can happen when the medical record lacks important information. This material was originally published in ISMIS' "Antidote" newsletter (Vol. IV, No. 2) in March of 1986.

The patient in this case had a history of heart disease and suffered a myocardial infarction after undergoing a hernia repair. He brought suit against his family physician, the estate of his surgeon, and the surgicenter operated by the surgeon. It was alleged that the patient was not a proper candidate for an elective surgery, should not have undergone one-day ambulatory surgery, was not properly maintained on his heart medication, was not monitored properly postoperatively, and was discharged home prematurely.

Case Description

A family physician referred a 53-year-old male to a surgicenter for "same day surgery" for elective repair of a symptomatic left inguinal hernia. The family physician was concurrently managing the patient's other medical problems, which included mild hypertension and a history of an inferior wall myocardial infarction four years previously. The patient's present status was stable. Medical management consisted of a beta blocker and oral nitrates. In fact, the patient was engaged in a regular exercise program, but the exercise seemed to aggravate the hernia and was a compelling reason to have it repaired. All of these matters were discussed in a telephone conversation between the referring physician and the surgeon.

With surgery scheduled for 8:00 a.m., the patient was admitted to the surgicenter at 6:30 the morning of surgery. He had remained NPO since midnight. The medical records contained only a short history and physical exam. A surgical nurse practitioner completed the medication and allergy list.

The anesthesiologist next discussed with the patient the technique of local anesthesia with IV sedation and general standby. A premedication was administered at 7:00 a.m. The remainder of the preoperative medical record consisted only of routine preop labs, EKG and CXR, which were obtained the day prior to surgery. The results were within normal limits except the EKG tracing, which revealed evidence of an old inferior wall myocardial infarction.

The procedure began at 8:00 a.m. and lasted 55 minutes. One-half percent lidocaine, a total of 200mg, was used to obtain adequate anesthesia. In addition, IV fentanyl was administered to supplement the local anesthesia. The anesthetic record reveals mild fluctuations in systolic BP during the procedure, ranging from 90 to 160mmHg. In the recovery room, the patient remained stable except for mild elevation of heart rate (110bpm) and some increased sedation secondary to the IV fentanyl. The patient left the recovery room and was taken back to his observation room in no apparent distress.

At noon the patient received a liquid diet. He complained of slight nausea and gas bloating, but the nurse told him it was merely because he had not eaten in a while. The chart did not indicate emesis or a significant change in vital signs. Although unknown to any medical personnel, the patient testified he took one sublingual nitroglycerin, which his wife carried at all times in her purse, as he did occasionally when experiencing "bloating and chest pressure."

The remainder of the afternoon was unremarkable. He was allowed to ambulate and voided without difficulty.

At 4:00 p.m. he was discharged with written instructions to return to his surgeon's office for follow-up in 48 hours, and to his family physician as needed. He was told he would receive a follow-up phone call from the nurse practitioner the next morning to check on his status. A prescription for acetaminophen with codeine was given to the patient at time of discharge. Nothing was mentioned about his heart medications.

After his evening meal, the patient again experienced nausea. On this occasion, his bloating and chest pressure were not relieved by two sublingual nitroglycerins. The patient then took one of the acetaminophen with codeine tablets. The discomfort, however, persisted for ninety minutes, during which time he experienced mild shortness of breath and slight diaphoresis. His wife called their family physician, who advised them to go to the emergency room. There the family physician examined the patient and confirmed the presence of an acute injury pattern in the lateral wall with the old changes of IMI. The patient was admitted to CCU and remained in the hospital eight days with an uneventful recovery from his recent myocardial infarction and his herniorrhaphy.

Upon discharge, the patient's medical management once again consisted of a beta blocker and oral nitrates. At a six month follow-up, the patient reported a decreased exercise tolerance following the second MI but no problems relating to the hernia repair.

Nine months following surgery, the patient filed suit against the now deceased surgeon, family physician, and the surgicenter. The jury found for the plaintiff and against all three defendants.

Legal Viewpoint

The plaintiff's expert, a cardiologist, testified that although a presently stable patient with a past history of MI is a reasonable candidate for outpatient surgery, the patient must be warned of the risks inherent in the surgery. The family physician testified that the surgeon had agreed to obtain an informed consent, but the plaintiff testified that all anyone told him was that there was nothing to worry about and to sign the form. That, the plaintiff's expert witness testified, does not constitute informed consent.

Second, the plaintiff's expert witness faulted the family physician for not providing more input into the patient's preoperative and postoperative management. The witness felt that the surgeon may have had little knowledge of the patient's regular medications and the need to continue them in the perioperative period. In his opinion, it was incumbent on the family physician to either actively participate in the perioperative management or at least specifically to request that the drug therapy be continued.

The family physician testified that during the telephone call in which he referred the patient, he told the surgeon that it was necessary to continue the heart medication and that the patient should be monitored closely postoperatively for any heart involvement. Neither made any record of that conversation.

Obviously something "fell between the cracks." The heart medication was not given during the immediate preoperative and postoperative period, and the surgeon did not monitor the patient himself nor sufficiently instruct the nurses to monitor the patient for signs of heart involvement.

Because the surgeon died, no one will ever know whether at trial he would have acknowledged that the family physician had cautioned him to be conscious of the heart condition or whether he would have testified that he was not aware of the necessity of any extra precautions. What we do know is that the jury was extremely skeptical of a family physician who testified that someone, who could no longer tell his side to the jury, had agreed to obtain an informed consent, to order heart medication and to monitor the patient's heart condition. There was no corroboration of any kind to support this testimony, only the family physician's unsupported word.

Obviously, the referring physician could have better defended his position, regardless of whether the surgeon had lived, if he had only noted in his records that he had told the surgeon of the patient's medication requirements and the need for the patient to be monitored. And, more importantly, there is a greater likelihood of the family physician's recommendations being followed when the recommendations are documented in the record.

Exchange Insights is not intended to provide legal advice, and no attempt is made to define conduct which would have been appropriate in particular cases to meet acceptable standards of care.

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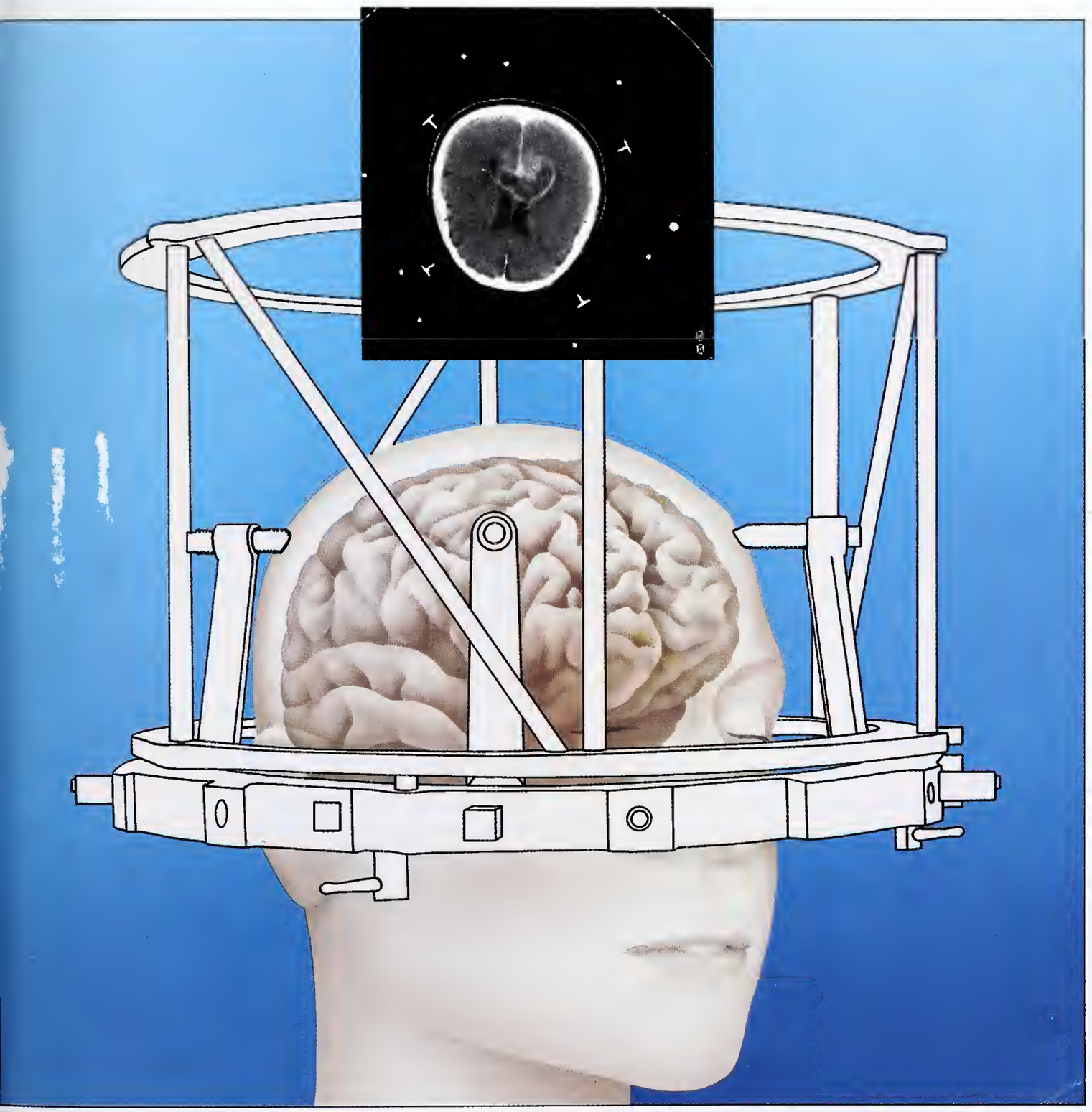
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Modern Stereotactic Neurosurgery . . . 89



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REPORT FOR *Illinois Physicians*

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Also, many hospitals in Illinois are submitting claims electronically for physicians. You can contact your hospital's business office for information about submitting your Blue Shield and Medicare "B" claims. A future report will list the service bureaus.

If you already have the capability to submit claims electronically and are interested in billing us directly or you would like further information on hospitals, or software vendors listed, please call us at (312) 938-7697.

MEDICARE NOTES

PURCHASED DIAGNOSTIC TESTS—ADDITIONAL INFORMATION

As you were informed in our April 1988 Major Mailing (pages 43-45), global billings are no longer accepted when the physician is *purchasing the test from an outside supplier.*

When a physician purchases a technical component (the services of the technician) from an outside supplier, use the appropriate procedure code for the test, followed by Modifier TC (Technical Component). Indicate the acquisition cost (net any discounts—remember "NO Mark-Up"), along with the supplier's name, address, and Medicare B provider number. Box 22 of the HCFA-1500 claim form must be checked "Yes". *You must accept assignment* & can collect only the 20% co-insurance and/or any unmet deductible from the patient.

When billing the professional component (physician's service), use the appropriate procedure code for the test, followed by Modifier 26 (Professional Component), and indicate your charge. **If you are a non-participating physician, your charge is limited to the MAAC shown on your MAAC report in the TOS-*D* column. If you have no pricing in TOS-D, request that information by procedure code from Medicare B, Freedom of Information, P.O. Box 992, Marion IL 62959.

Outside suppliers *may* bill separately for the technical component, if they choose. In order to do so, they require a Medicare B provider number. In this situation, the physician would bill for the professional component *only*, as described above, adding the information "Supplier billing separately for technical component". When the supplier is billing directly for the technical component, he/she would bill as described above (for the technical component), using the appropriate procedure code, followed by Modifier TC.

If both professional & technical components of the diagnostic test are **personally performed** by the physician or by his own employees under this direct supervision, **global billing is required.** Box 22 on the HCFA-1500 claim form should be checked "No". You do not have to accept assignment when "personally performing". Additionally, if you do not complete a HCFA-1500 claim form for your patients, indicate "personally performed" or "no purchased test" on the statement or superbill you give to your patients. Adding this *required* information to your statement or superbill will enable Medicare B to pay those *patients who file their own claims.*

REMINDER: MONITORED ANESTHESIA

"Monitored" anesthesia is covered by Medicare B when the patient's medical record documents that the service was *personally performed* as described below:

As stated in the Medicare Carriers Manual, "monitored anesthesia care involves the intraoperative monitoring by a physician, or by a qualified individual under the medical direction of a physician, of the patient's vital physiological signs, in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a preanesthetic examination & evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., Etropine, Demerol, Valium) & provision of indicated post-operative anesthesia care."

Stand-by anesthesia is *not covered* by Medicare B as stated in the June 1988 Blue Sheet.

Post-pay audits will be performed to assure compliance with monitored anesthesia documentation requirements.

ADDITIONAL INFORMATION: CONCURRENT CARE/DISEASES COMMON TO THE ELDERLY

Claims will be reviewed for both diagnoses and the specialty of both physicians. When two physicians with the same or similar specialty provide the same service (i.e., medical care) the diagnoses will be used in making the coverage determination. *Generally,* secondary diagnoses common to the elderly population will not be considered as diagnoses requiring specialized medical care by a second physician *except under unusual circumstances which are clearly explained on the claim.* Diagnoses considered common to the elderly are listed below. When two physicians submit claims with one or more of these diagnoses, the first claim received will be allowed and the second claim will be denied as *duplicate care unless unusual circumstances existed and are clearly documented on the claim.*

Diagnoses considered common to the elderly are:

Arthritis	Organic Brain Syndrome
Osteoarthritis	Hemorrhoids
ASHD	Hypertension*
Arteriosclerosis	Bronchitis*

*will be allowed as secondary diagnoses requiring concurrent care when a surgical specialty and a medical specialty are billing and there is *evidence on the claim that the patient had surgery.*

(This report is a service to the physicians of Illinois)

IMJ

Illinois Medical Journal
Illinois State Medical Society

Volume 174, No. 2
August 1988

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On Vacation



Many of us enjoy extra personal time in the summer months. We may even try to fool ourselves into believing that we can take a vacation from medicine.

But a doctor on vacation is still a doctor. The judgments and choices that map a therapeutic course shape a world view. The human and intellectual elements which make medicine an art and a science are fun. But we also learn early on that life is a balancing act between needs and resources which rarely match up. And the elements on the scale sometimes offer troublesome choices.

Making time for diversion yields valuable perspective. It's almost obligatory.

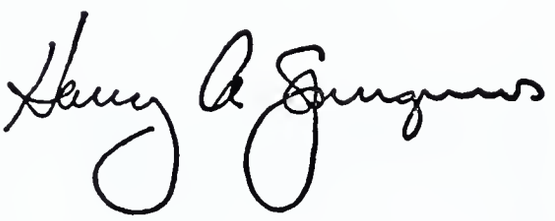
I like to drive race cars. Once or twice a year, I spend a few days in open wheel auto running time trials. The absolute concentration enables me to depart, however briefly, from day-to-day concerns. It's a stimulating change and it's fun.

But it's probably best that racing weekends are rare departures. Vacation more often means a time of quiet with friends and family. These more gentle experiences make up the fabric against which we make the split-second judgments our work requires. They give us a context.

In the fall, we'll start in again with the school-year schedule of hours and meetings and CME. We'll see a new legislative session, hear results on the federal relative value scale study and observe the usual cacophany that announces we're back to full speed.

If the reality of the day requires that our work be codified and charted, we'll have to do our part to make those codes and charts accurate. If a legislative proposal threatens access to care for our patients, we'll have to get on the phone to our representatives. If a regulatory body fails to implement good laws which help our patients, we'll have to object.

Come fall, we'll be back to the business of ensuring that components of the balancing act don't fall too far from center. The present provides an opportunity to stand back and reflect on what those components are and what new directions to pursue next. ◀



Harry A. Springer, M.D.
President

ABSTRACTS OF ACTIONS

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

June 11, 1988 *ISMS Conference Complex*

DEPARTMENT OF PROFESSIONAL REGULATION

Recently the Department of Professional Regulation (DPR) issued nearly 4,000 warning letters to physicians who allegedly failed to renew their licenses by July 31, 1987. (The Department was formerly called the Department of Registration and Education.)

The letter in question, according to DPR, was never intended to be part of a physician's record. It is not considered a disciplinary action, but is intended to show a potential violation if the Act's requirements are not met. The Director of DPR provided a letter of explanation and information as to this administrative warning letter. Based upon this, the Executive Committee directed an all-member mailing citing the explanatory comments in the letter from the Director of DPR.

Since ISMS nominates physicians to serve on the Medical Licensure Board and the Medical Disciplinary Board, it was determined that closer liaison should exist. The Board agreed to invite a representative from the Medical Licensure Board and from the Medical Disciplinary Board to make a presentation to the ISMS Board of Trustees twice a year. The Director of the Department of Professional Regulation will also be invited to discuss issues with the leadership.

CONTRACT REVIEW

A year ago, the ISMS Board of Trustees began a review of the ISMS contract review service used by a relatively small segment of the membership. The Board determined that a greater share of the expenses of the contract review service should be paid by those using it, and directed that a $100.00 charge be placed on individual reviews, effective January 1, 1988.

There is a need to communicate significant potential contractual issues to the membership. In order to utilize dues dollars more wisely, the Board approved modification of the current contract review service. An ongoing statewide educational effort for the membership on issues which pertain to contracts was initiated. This effort may include seminars, brochures and *IMJ* articles. If administratively possible, staff was further directed to maintain individual contract review for individual physicians, at their own expense.

COMMITTEE ON DRUGS AND THERAPEUTICS

The Board approved that the following drug products be recommended for inclusion in the IDPA Drug Manual: Mevacor (lovastatin); Maxair Inhaler (pirbuterol acetate); Axid (nizatidone); MS Contin (morphine sulfate controlled release).

The Board also recommended that IDPA not include Prolastin or Nitrol Applikit in its Drug Manual.

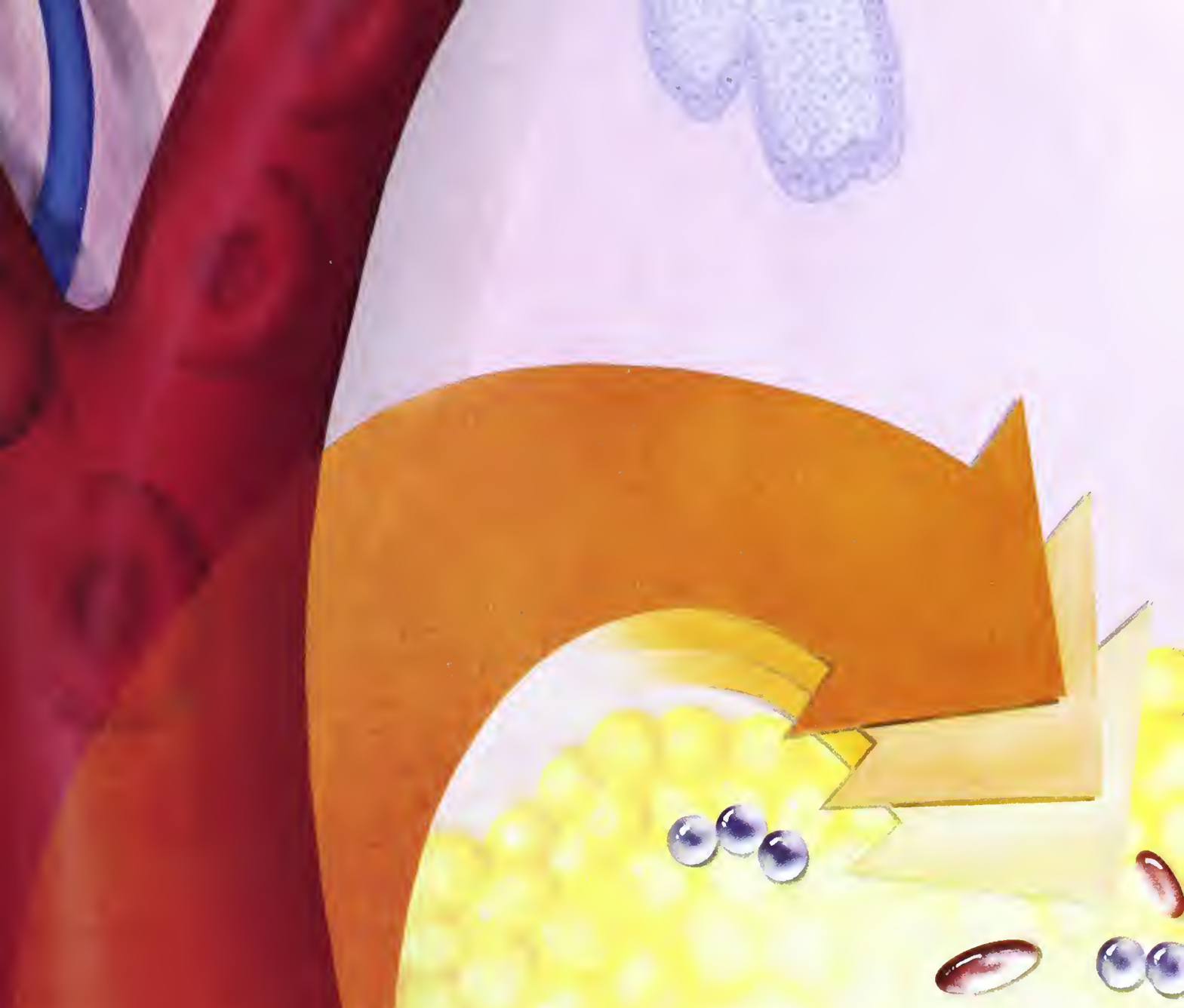
The Committee on Drugs and Therapeutics has requested that IDPA bring to its attention other brands of generic benzodiazipam for possible inclusion in the IDPA Drug Manual. As a result, the Board further recommended that IDPA now include Lorazepam, Oxazepam, Clorazepate and Temazaepam in its Drug Manual.

OTHER ACTIONS

In addressing various other issues, the Board:

- Filed the: March 31, 1988, Financial Statements; May 25, 1988, IMPAC Collection Data; May 25, 1988, Dues Payment Report; and Adopted Requests for Changes in Membership Status.
- Approved the following Board meeting schedule: September 10, 1988; November 4, 1988 (All-Member Conference/Interim Meeting); January 21, 1989; April 6, 1989 (Annual Meeting); June 10, 1989; September 16, 1989.
- Agreed to hold an All-Member Conference November 5, 1988, at the Renaissance Hotel in Springfield.
- Agreed to endorse the 1989 candidacy of Dr. John J. Ring, for AMA trustee.
- Approved introduction of an Illinois resolution to the AMA entitled Tissue Plasmagenic Activator (TPA), which urges the HCFA to recognize the additional costs associated with the appropriate use of TPA and adjust reimbursement rates accordingly.
- Authorized the Chairman of the Board to express ISMS concerns on the proposal to eliminate area prevailing profiling by medical specialty to the appropriate entities.
- Approved legislative positions delineated in a primary list of House and Senate bills of interest to ISMS.
- Agreed to draft and cause to be introduced legislation amending the Workers' Compensation Act to require written authorization for the release of patient records.
- Approved the production and promotion of the revised "Due Process Guidelines for Physicians,"

(continued on page 111)



Penetration plus Duration*

Superior tissue penetration and duration of action

DURICEF®

(CEFADROXIL)

... the oral cephalosporin with once- or twice-a-day dosing

*May not correlate with clinical results.

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For Brief Summary, please see following page.

DURICEF® (CEFADROXIL)
Penetration plus Duration
in Oral Cephalosporin Therapy

INDICATIONS: DURICEF (cefadroxil) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms: Urinary tract infections caused by *E. coli, P. mirabilis,* and *Klebsiella* species. Skin and skin structure infections caused by staphylococci and/or streptococci. Pharyngitis and tonsillitis caused by Group A beta-hemolytic streptococci. (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. DURICEF is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of DURICEF in the subsequent prevention of rheumatic fever are not available at present.)
Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.
CONTRAINDICATIONS: DURICEF is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.
WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF PENICILLINS AND CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE).
Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil). **Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.** Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated. When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should also be considered.
PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).
DURICEF (cefadroxil) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 ml/min/1.73M²). (See Dosage and Administration section of Prescribing Information.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.
Prolonged use of DURICEF may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.
Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug. DURICEF should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
Usage in Pregnancy: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to 11 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cefadroxil. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.
Nursing Mothers: Caution should be exercised when cefadroxil is administered to a nursing mother.
ADVERSE REACTIONS: *Gastrointestinal*—Symptoms of pseudomembranous colitis can appear during antibiotic treatment. Nausea and vomiting have been reported rarely.
Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug.
Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.
Before prescribing or administering, see package insert.

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SPECIAL ARTICLE

Team Physician Awards

Five physicians were winners of the 1987-88 ISMS Team Physician Awards: Albert F. Cunningham, Normal; Russell E. Gibson, LaGrange; James L. Green, Jacksonville; Paul J. Jorden, Carol Stream; and Thomas P. Regan, Palos Heights.

Winners were selected among physicians who had provided ten years of voluntary service to their local schools treating young athletes and educating coaches, trainers, parents and athletes about the importance of prevention and treatment of injuries. Each was an ISMS member who had worked in sports medicine and had also served their communities in a variety of ways.

The ISMS Team Physician Award was established in 1982 to recognize physicians who dedicate themselves to young athletes of their communities. The ISMS Sports Medicine Committee solicits nominations from all high schools, colleges, and county medical societies throughout the state. Over 50 physicians were nominated for this year's awards, which were presented March 17.



The 1987-88 recipients of the ISMS Team Physician Awards, given to physicians who have dedicated themselves to providing services to the young athletes of their communities. (L-R) Albert F. Cunningham M.D., Normal; Russell E. Gibson, M.D., LaGrange; Paul J. Jorden M.D., Carol Stream; James L. Green M.D., Jacksonville. The fifth award winner, not pictured, is Thomas P. Regan, M.D., Palos Heights.



Carafate® for the ulcer-prone NSAID user

Aspirin and other nonsteroidal anti-inflammatory drugs are known to weaken mucosal defenses by inhibiting prostaglandin production. As a result, NSAID users may be more prone to duodenal ulcers.[1] For these patients, CARAFATE® (sucralfate/Marion) is first-line therapy that won't knuckle  under. Carafate rebuilds mucosal defenses, including endogenous prostaglandins, through a unique, nonsystemic mode of action. Carafate works by enhancing the body's natural healing ability while it protects damaged mucosa  from further injury. Carafate offers a local healing approach to a local problem, allowing patients to continue their NSAID therapy. So the next time you see an arthritis patient with a duodenal ulcer, prescribe nonsystemic Carafate: therapy for the ulcer-prone patient.

Nothing works like

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Please see brief summary of prescribing information and reference on adjacent page

1337E8

CARAFATE®
(sucralfate) Tablets

BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE
There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other.

Issued 1/87

Reference:
1 Eliakim R, Ophir M, Rachmilewitz D. *J Clin Gastroenterol* 1987, 9(4):395-399.

Another patient benefit product from
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1337E8

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

September

Anesthesiology

The Use and Interpretation of Monitoring and New Technologies
For: Anesthesiologists. Symposium, Sept. 9-11, Chicago, IL. **Sponsor:** University of Chicago School of Medicine, Center for CME, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** $275. **Reg. Limit:** 250. **Credit:** Category 1: 15.5 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Cardiology

Advances in Echocardiology
For: Cardiologists. Symposium, Sept. 8-9, Chicago, IL. **Sponsor:** University of Chicago School of Medicine, Center for CME, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** $100. **Reg. Limit:** 200. **Credit:** Category 1: 11 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Dermatology

Specialty Review in Dermatology
For: Dermatologists. Lecture, Sept. 19-24, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 39 hours; AAD Category 1: 39 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Family Practice, Otolaryngology

TMJ Disease: A Multidisciplinary Problem
For: Physicians and other interested professionals. Conference, September 16-17, Madison, WI. **Sponsor:** UW-Madison, CME, Dept. of Surgery, Division of Plastic and Reconstructive Surgery, School of Medicine, 2715 Marshall Court, Madison, WI 53705. **Fee:** To be announced. **Reg. Limit:** None. **Credit:** Category 1: 9 hours; UW CME: 9 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

General Practice

41st Annual Clinical Refresher Course
For: General and Family Practitioners. Lectures and workshops, Sept. 28-Oct. 1, Oak Brook, IL. **Sponsor:** Chicago College of Osteopathic Medicine, 5200 S. Ellis Avenue, Chicago, IL 60615. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1: 21-27 hours. **Contact:** Marie E. Kowalsky. **Phone:** (312) 947-4606.

Immunology, Family Medicine

Immune Deficiency and Vaccines
For: Physicians and other health professionals. Conference, Sept. 22-24, Madison, WI. **Sponsor:** UW-Madison, CME and the Department of Medicine, School of Medicine, UW-Madison, 2715 Marshall Court, Madison, WI 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1: 17 hours; AOA Category 2-D: 17 hours; UW CEH's: 17 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Internal Medicine

Specialty Review in Pulmonary Disease
For: Internists and pulmonologists. Lecture, Sept. 26-30, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. Credit: Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Specialty Review in Infectious Disease
For: Internists and infectious disease specialists. Lecture, Sept. 26-30, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Specialty Review in Hematology
For: Hematologists, oncologists, and internists. Lecture, Sept. 26-30, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Internal Medicine, Rehabilitation

Dizziness, Vertigo and Unsteadiness: A Review of the Latest Developments in Diagnosis and Treatment
For: Family practitioners, physiatrists, otolaryngologists, audiologists, other health professionals. Course: September 17-18, Chicago, IL. **Sponsor:** Rehabilitation Institute of Chicago, 345 E. Superior Street, Chicago, IL 60611. **Fee:** physicians—$175; medical residents and allied health professionals—$125. **Reg. Limit:** 100. **Reg. Deadline:** September 10. **Credit:** Category 1: 11 hours. **Contact:** Dr. Don A. Olson. **Phone:** (312) 906-6179.

13th Annual Spinal Cord Management Seminar: Update for the 1990s and Predictions for the Year 2000.
For: Physicians, nurses, OTs, PTs, psychologists, social workers, vocational specialists. Course: September 28-October 1, Chicago, IL. **Sponsor:** Rehabilitation Institute of Chicago, 345 E. Superior Street, Chicago, IL 60611. **Fee:** $200. **Reg. Limit:** 90. **Reg. Deadline:** September 19. **Credit:** Category 1: 14.75 hours. **Contact:** Dr. Don A. Olson. **Phone:** (312) 908-6179.

Ophthalmology

Cornea, Cataract and Lasers '88
For: Ophthalmologists. Symposium, Sept. 17, Chicago, IL. **Sponsor:** University of Chicago School of Medicine, Center for CME, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** TBA. **Reg. Limit:** 200. **Credit:** Category 1: TBA. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

(continued on page 106

A Progress Report

Medical Necessity Denial and Refund Letters

At its 1988 Annual Meeting, the ISMS House of Delegates directed that the Society provide information on Medicare payment denials tied to medical necessity. The House stipulated that suggested language to advise patients about potential Part B denials, refunds and patient liability should be included in the membership information. This article gives a status report of ongoing efforts to address the issue.

The Health Care Financing Administration (HCFA) now requires that physicians who do not accept assignment must refund patient payments for Part B claims denied on the basis of "medical necessity."

This provision became law under the Omnibus Budget Reconciliation Act of 1986, effective for dates of service on or after October 1, 1987. It affects only claims for which assignment is *not* accepted and has no direct impact on participating physicians because they agree to accept all Medicare assignments under the participation agreement.

Once the Medicare Part B carrier determines that a non-assigned claim is not medically necessary, the physician and the beneficiary are advised that Part B reimbursement for the service or procedure has been denied. The notification states that the physician *must* refund to the beneficiary any monies collected for services denied as not medically necessary. It advises that failure to comply may result in civil monetary penalties, and outlines appeal procedures. (The physician may request a review of the findings or, if appropriate, a hearing.)

There are exceptions. If the physician can demonstrate that he/she did not or could not have known the service would be denied, he/she can seek a waiver of liability. If granted, this absolves the physician from refund provisions, but probably will not affect the original claim denial. An exception to refund can also be made if the physician informed the patient, prior to providing the service, that Medicare would not pay for it, and the patient agreed to pay. Timing is crucial: the patient must be advised of the potential denial, and must agree to pay the cost, before service is rendered. While the law does not require that physicians provide notice in writing when a medical necessity denial is likely, the carrier may later require acceptable proof of notification.

Many physicians have been frustrated by the need for appropriate wording and forms with which to advise patients that a particular service might be found "medically unnecessary" under Medicare. The Society has sought to assist the members in this area, and continues to pursue it.

ISMS Actions

The Illinois State Medical Society addressed this issue early on, raising strong protest and concern with the Illinois Congressional Delegation and the AMA. Efforts with the Congressional Delegation were no doubt partially responsible for HCFA's recent agreement to review this issue with the AMA.

ISMS was also instrumental in urging the development of the carrier's "claim development letter," which gives physicians an opportunity to provide additional data to Medicare to support "medical necessity." As a result of these efforts, Medicare now seeks supporting information from the physician prior to making a medical necessity denial on an unassigned claim. The

claim development letter gives physicians an opportunity to provide or verify accurate diagnostic data and justify the service provided. The claim development letter has reduced the number of medical necessity denials and beneficiary refund requests.

But the conflict is far from over. An ISMS House of Delegates resolution asking that the AMA seek repeal of this onerous refund provision was incorporated into the AMA's legislative policy. For the present, this refund provision remains federal law.

Medical Necessity Screens

How does a physician know when a service will not be covered? When is it likely that the carrier will find a service to be medically unnecessary and require a refund?

All claims, regardless of assignment status, are evaluated by carrier personnel against a series of prepayment review screens. Claims exceeding the maximum frequency or other criteria established by these screens may be denied. The reason for denial may be "medical necessity."

HCFA has developed at least 13 prepayment screening parameters. In addition, Part B carriers have their own prepayment utilization criteria. Claims denied as not medically necessary are not reviewed by health care professionals for appropriateness. Rather, they are screened by claims processing personnel for compliance with prepayment guidelines.

For example, 31 consecutive hospital visits per month (a HCFA parameter) should be paid without a "medical necessity" question. However, a 32nd visit would be rejected and supportive documentation would be required for payment. Failure to produce supporting data would result in a medical necessity denial and a refund.

Similarly, the carrier may consider a specific number of office visits to be excessive. Claims exceeding that maximum will require documentation to support payment. ISMS is attempting to obtain all the applicable claim processing, utilization or prepay criteria. (Current HCFA prepayment screens are shown above.)

HCFA Medicare Screening Parameters

Screen	*Parameter*
1. Routine Foot Care (excludes mycotic nails)	One treatment every 60 days. (HCPCS T1060)
2. Mycotic nails	One treatment every 60 days. (HCPCS 11700, 11701, 11710, 11711)
3. Nursing home visits	One per month. (HCPCS 90430-90470, W9051-W9059)
4. New patient office	Comprehensive physical examinations, one per carrier history period by the same provider. (HCPCS 90020)
5. Holter monitoring	No more than one instance per 6 months. (HCPCS 93258-93263, Q0019-Q0026)
6. Chiropractic	Twelve per year. (HCPCS A2000)
7. Concurrent Care	Same date of in-hospital service, different practitioner, same or similar specialty.
8. Hospital Visits	31 per month; 31 per 3 months. (HCPCS 90240-90280)
9. Comprehensive Office Visits	Established patient comprehensive level, 1 visit per 6 months. (HCPCS 90080)
10. Skilled Nursing Facility (SNF)	Subsequent care 2 first week, 1 per week thereafter. (HCPCS 90340-90370, W9042, W9043, W9045, W9046)
11. Injections	All injections, no more than 24 per year except B-12, allergy, joint, or chemotherapy injections.
12. Urological Supplies	No more than 2 per month. (HCPCS A4341-A4346, A4353, A4354, W9830, W9832, W9842)
13. Replacement of post cataract external prosthetic contact lens	One external lens replacement per eye per year. (HCPCS V2500-2599)

Minimizing Refunds and Denials

Claims for services which do not conform to the screening parameters cause denials and refunds. These can be avoided or minimized if the physician ensures that:

- Supporting documentation and initial claim submission is clear, concise and specific to the service provided.
- Additional documentation is provided when appropriate.
- When appropriate, the physician advises the patient that a claim may be denied on the basis of medical necessity and the patient agrees in advance to pay for it.

Further, office staff should carefully watch several key areas when submitting Part B claims:

- *Services that could exceed stated HCFA or carrier parameters.*

 When submitting a claim that may exceed carrier payment criteria, include documentation with the initial claim submission to support the services provided.
- *Vague or nonspecific procedures or diagnoses.*

 This may be a common result on beneficiary-completed and/or

submitted claims. For example, complaints of back pain, joint soreness, or headache may seem vague to claims processing personnel. And procedure codes or diagnostic codes that identify an unlisted procedure and/or diagnosis (although the code may be from the appropriate reporting terminology) may cause a medical necessity denial. Services, procedures, and diagnoses should be clearly identified.

- *Violation or apparent violation of the carrier's concurrent care policy.*

The carrier issued a booklet in April, 1988, outlining its concurrent care policy. The carrier will deny any claim that appears to be duplicative. If the carrier receives a claim from two physicians for the same procedure or service, it will pay only one. Physicians billing for potential concurrent care claims should note only the services they directly provided and the diagnoses they directly treated.

For example, if a patient admitted for gallbladder surgery also has a severe diabetic condition, both the surgeon and the attending physician can receive reimbursement if: (a) the surgeon only bills and notes the diagnosis related to surgery; and (b) the attending physician bills and notes only the services related to the diabetic monitoring. Where two physicians provide care to a single patient, each must carefully specify the particular condition he or she individually treated.

A duplicative service denial may also occur if one physician performs surgery while another (of the same or different medical specialty) provides routine follow-up hospital care. Emergency conditions may be exempt but should be clearly identified on the billing form. Illinois carriers' concurrent care guidelines are presently under HCFA review.

Advising Patients

We have reviewed the requirements of this law, reasons triggering a refund letter and ways to minimize these problems on the front end. The next component in dealing with medical necessity denials is advance beneficiary notification.

In April, the carrier circulated a form for physician use in advising patients that a service might not be covered or might be denied under medical necessity criteria. Since this form was devised by the carrier, it can be assumed that physicians who use it to advise patients of their financial liability and possible Part B denial meet HCFA's beneficiary notification criteria.

But this is a fluid issue, open to continued update and change by HCFA. HCFA is currently in the process of developing suggested language for use by physicians in beneficiary notifications on medical necessity denials. Additionally, as a result of AMA negotiations, HCFA has agreed to review the current refund letter sent to beneficiaries in the event of a medical necessity denial to eliminate some of the objectionable language.

However, HCFA believes that beneficiary notification on this issue should not be a common occurrence. HCFA will not accept blanket statements that a Medicare denial is possible, or general notices indicating that the patient agrees to pay, should Medicare deny the claim. HCFA considers these types of statements to be too broad. The notice must identify the specific service which might be denied. HCFA's latest transmittal on this issue indicates that an acceptable beneficiary notification must also tell why the physician believes that the carrier might deny the claim.

Requiring that a physician speculate as to whether or not a claim will meet unpublished and unspecified billing criteria for payment is clearly not acceptable to ISMS or the AMA. This is the subject of ongoing AMA negotiations with HCFA. ISMS had hoped to develop a sample form and proposed language for physician reference in developing individual beneficiary notifications. However, because of HCFA's latest transmittal, ISMS cannot meet the House of Delegates' request for alternative language or sample forms on beneficiary notification at this time.

The carrier has indicated that the form provided in April will be modified to meet HCFA revised guidelines on this issue. Acceptable wording is the subject of discussion between HCFA and the AMA. ISMS will continue to track these discussions and advise the membership as appropriate.

However, in the absence of HCFA-approved language, the following guidelines are offered:

- Be as specific as possible in identifying the potential denial to the patient.
- Indicate that although the service may not meet Part B payment guidelines it is your professional judgment that the service is necessary and appropriate to quality medical care.
- Keep a copy of any beneficiary notification in the patient's record.

ISMS will continue to advise the membership as these matters evolve and to work toward sample forms for physician use. Physician inquiries on this issue can be directed to the ISMS Division of Health Care Finance. ◀





Transderm-Nitro®

nitroglycerin 2.5 mg/24 hr, 5 mg/24 hr, 10 mg/24 hr, 15 mg/24 hr

Helps angina patients get more out of life

Significantly reduces both the frequency of anginal attacks and the need for sublingual nitroglycerin[1]

Preferred by patients over 7 to 1 for convenience compared to their previous long-acting oral nitrate; only 12% had no preference (n = 4,300)[2]

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA.
Please consult Brief Summary of Prescribing Information on the following page.

CIBA

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Transderm-Nitro® nitroglycerin
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INOICATIONS ANO USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA

CONTRAINOICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued
Transderm-Nitro system is not intended for immediate relief of anginal attacks For this purpose occasional use of the sublingual preparations may be necessary

AOVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage When they persist the dose should be reduced or use of the product discontinued In some patients, dermatitis may occur

OOSAGE ANO ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest, if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area
Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 mg/24 hr system
Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system More systems may be added as indicated by continued careful monitoring of clinical response The Transderm-Nitro 2 5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

Printed in U.S.A. *629-5551-A* C87-23(Rev. 7/87)

C I B A

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

1. Martines C: Comparison of the prophylactic anti-anginal effect of two doses of Nitroderm TTS in out-patients with stable angina pectoris. *Curr Ther Res* 1984;36:483-489.
2. Brady EM, Gold OG, Rosenbach H: Transdermal nitroglycerin antianginal comparative trial involving oral nitrates: The Transderm-Nitro A.C.T.I.O.N. Study Presented at 2nd Cardiovascular Pharmacotherapy International Symposium. San Francisco, October 1987.

Why Invest in Continuing Education?

By Rose M. Hall, RN, CMA-AC/Belleville

"I don't have the time."

"My doctor's not interested."

"I tried to get my girls to go but they're not interested."

"It costs too much."

"Most of the information isn't needed in my practice."

These are typical reasons given by medical assistants and physicians for failure to participate in continuing education programs for medical assistants.

The first response should be, "Doctor, you can't afford *not* to send your medical assistants." Technology and procedures change rapidly and they will continue to change. In the last five years, laboratory testing methods have been introduced in a steady stream. Personnel laws change continually. There has been increased competition for the patient population, and patients themselves have become more sophisticated, demanding more information and explanation.

More very ill patients, who in the past would have been admitted to hospitals, are now treated at home. There is an expanded need to notify patients of follow-up visits. Because of increased government intervention in setting fees and codes for treatment, procedure codes must be continually updated and documentation of visits must be accurate and consistent with the diagnosis to insure payment.

Careful attention must be given to collection and auditing of insurance payments to improve cash flow. HMOs and PPOs have specialized billing systems. Cost effective inventory systems and personnel management become important in a time of increased costs.

Now that the areas in need of attention have been identified, who can help? Several staff members could prepare inservice educational programs or describe the ways in which office systems are integrated.

For assistance outside the office, consult with allied health and administrative staff persons in hospitals, pharmacies, and public health departments. There may also be a medical assistant association in the area, which can help in the preparation of educational programs where the staff may obtain the continuing education units necessary to maintain certification. Or there may be a community college program to provide continuing education courses for credit.

A more expensive route for continuing education is the one day seminar presented by management consultants. Participants should be encouraged to summarize and rate the program as to its relevancy and accuracy.

It is important to employ medical assistants knowledgable about new technologies and interested in continuing education.

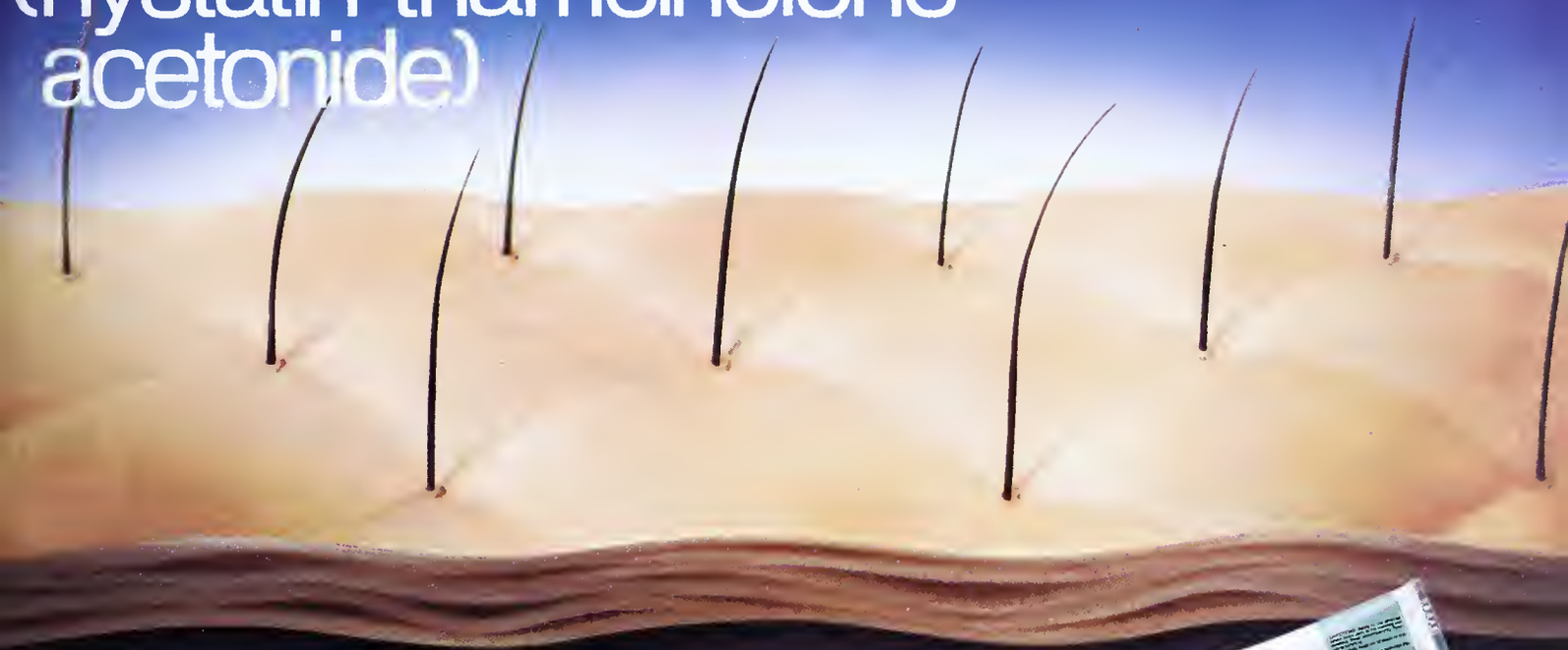
A patient's perception of a physician begins with the office staff. A well-informed, intelligent medical assistant improves overall public relations and increases trust in the physician—a worthwhile goal. ◀

Announcing a new benefit beyond price alone.

Advanced Formula

Mytrex®

(nystatin-triamcinolone acetonide)



New—fragrance-free formula

- ☐ Avoids the #1 irritant in cutaneous reactions[1]
- ☐ No methylparaben, propylparaben, or ethylenediamine
- ☐ Virtually nonsensitizing vanishing cream base

Uncompromised anticandidal effectiveness

- ☐ Faster, more thorough control of erythema and pruritus than nystatin or triamcinolone alone
- ☐ Unexcelled control of pruritus ani, candidal diaper rash, intertriginous fungal infections associated with diabetes mellitus or chronic maceration

Convenience for compliance



- ☐ b.i.d. regimen
- ☐ Both popular dosage forms—cream and ointment

...and still economical

Please see facing [following] page for brief summary of prescribing information.

Systemic absorption of topical corticosteroids has produced reversible HPA suppression manifestations of Cushing's syndrome, hyperglycemia and glucosuria in some patients. Pediatric patients may demonstrate a greater susceptibility.

Reference: 1. Adams RM, Maiback HI, Clendenning WE, et al: A five-year study of cosmetic reactions. *J Am Acad Dermatol* 1985;13(6):1062-1069.

SAVAGE LABORATORIES
a *division of Altana, Inc.*
Melville, New York 11747

Mytrex® CREAM AND OINTMENT, USP
(nystatin-triamcinolone acetonide)

Brief Summary of Prescribing Information

For Dermatologic Use Only
Not for Ophthalmic Use

INDICATIONS AND USAGE: For the treatment of cutaneous candidiasis; it has been demonstrated that the nystatin-steroid combination provides greater benefit than the nystatin component alone during the first few days of treatment.

CONTRAINDICATIONS: This preparation is contraindicated in those patients with a history of hypersensitivity to any of its components.

PRECAUTIONS: General: Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings (see DOSAGE AND ADMINISTRATION). Therefore, patients receiving a large dose of any potent topical steroid applied to a large surface area should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests, and for impairment of thermal homeostasis. If HPA axis suppression or elevation of the body temperature occurs, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis' function and thermal homeostasis are generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids. Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity (see PRECAUTIONS, Pediatric Use). If irritation or hypersensitivity develops with the combination nystatin and triamcinolone acetonide, treatment should be discontinued and appropriate therapy instituted.

Information for the Patient: Patients using this medicine should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occluded (see DOSAGE AND ADMINISTRATION).
4. Patients should report any signs of local adverse reactions.
5. When using this medication in the inguinal area, patients should be advised to apply cream sparingly and to wear loose fitting clothing.
6. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.
7. Patients should be advised on preventive measures to avoid reinfection.

Laboratory Tests: If there is a lack of therapeutic response, appropriate microbiological studies (e.g., KOH smears and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens, before instituting another course of therapy. The following tests may be helpful in evaluating hypothalamic-pituitary-adrenal (HPA) axis suppression due to the corticosteroid: Urinary free cortisol test; ACTH stimulation test.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic or mutagenic potential or possible impairment of fertility in males or females.

Pregnancy Category C: There are no teratogenic studies with combined nystatin and triamcinolone acetonide. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Therefore, any topical corticosteroid preparation should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Topical preparations containing corticosteroids should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Nursing Mothers: It is not known whether any component of this preparation is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised during use of this preparation by a nursing woman.

Pediatric Use: In clinical studies of a limited number of pediatric patients ranging in age from 2 months through twelve years, Nystatin-Triamcinolone Acetonide Cream cleared or significantly ameliorated the disease state in most patients. *Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced hypothalamic-pituitary-adrenal (HPA) axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area to body weight ratio.* HPA axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches and bilateral papilledema. Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.

ADVERSE REACTIONS: A single case (approximately one percent of patients studied) of acneiform eruption occurred with the use of combined nystatin and triamcinolone acetonide in clinical studies.

Nystatin is virtually nontoxic and nonsensitizing and is well tolerated by all age groups, even during prolonged use. Rarely, irritation may occur.

The following local adverse reactions are reported infrequently with topical corticosteroids. These reactions are listed in an approximate decreasing order of occurrence: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae and miliaria.

DOSAGE AND ADMINISTRATION: Cream: Apply MYTREX® (Nystatin-Triamcinolone Acetonide) Cream, USP to the affected area twice daily in the morning and the evening by gently and thoroughly massaging the preparation into the skin. Ointment: A thin film of MYTREX® is usually applied to the affected area twice daily in the morning and evening. MYTREX® should be discontinued if symptoms persist after 25 days of therapy. (See PRECAUTIONS, Laboratory Tests). MYTREX® should not be used with occlusive dressings.

Caution: Federal law prohibits dispensing without prescription.

R 4/87

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MYT6-1 6/88

ISMS Physician Help Line

Are you troubled by chemical dependency, alcoholism, physical or mental problems, or concerned about someone who has an impairment? Are you having emotional or physical problems dealing with your involvement in a malpractice suit?

If so, contact the PHYSICIAN HELP LINE, 312/580-2499, a confidential, advocacy service offered by the ISMS Physician Assistance Program and the Physician Support Group to link troubled physicians and their families with resources to help them.

Physician Help Line calls will be answered, as soon as possible, by Dr. Violet M. Eggert, Medical Director of the ISMS Physician Assistance Program.

Physicians wanted for leading clinic

Prestigious Chicago-based clinic group specializing in the treatment of venous disorders is in need of physicians trained in internal medicine—or who have a broad base of medical experience. We will provide complete training in the latest proprietary techniques of treating venous disorders. We offer a six figure salary and bonus potential, along with malpractice insurance and health benefits. And since there are no weekend hours and a 40-hour work week, you will have plenty of leisure time. You won't have to worry about soliciting for patients or fighting insurance companies.

This is an outstanding opportunity for professional and financial advancement. If you are motivated to build a rewarding practice with the leader in the treatment of venous disorders, send your resume to:

Medical Director
Vein Clinics of America
2340 S. Arlington Heights Road
Arlington Heights, Illinois 60005

OBITUARIES

Bannan, Denyse D., Orland Park, died February 6, 1988, at the age of 35. Dr. Bannan was a 1977 graduate of Loyola University Stritch School of Medicine, Maywood.

****Baxter, Edward S.,** La Grange, died April 5, 1988, at the age of 77. Dr. Baxter was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

Brueckner, David A., Chicago, died March 21, 1988, at the age of 48. Dr. Brueckner was a 1970 graduate of Washington University School of Medicine, St. Louis, Missouri.

***Carroll, John J.,** Belleville, died June 26, 1988, at the age of 66. Dr. Carroll was a 1946 graduate of Loyola University Stritch School of Medicine, Maywood.

Corey, Alexander L. III, Chicago, died March 22, 1988, at the age of 37. Dr. Corey was a 1978 graduate of Rush Medical College, Chicago.

***Chapman, Robert A.,** Belleville, died January 18, 1988, at the age of 67. Dr. Chapman was a 1945 graduate of the University of Illinois College of Medicine, Chicago.

Dye, Donald R., Park Ridge, died March 28, 1988, at the age of 62. Dr. Dye was a 1948 graduate of the Ohio State University College of Medicine, Columbus.

Gorgon, Harold, Chicago, died March 25, 1988, at the age of 62. Dr. Gorgon was a 1954 graduate of the University of Illinois College of Medicine, Chicago.

Hall, Wilson B., Quincy, died January 20, 1988, at the age of 75. Dr. Hall was a 1944 graduate of the University of Minnesota Medical School, Minneapolis.

****Indovina, Michael,** Homewood, died March 12, 1988, at the age of 85. Dr. Indovina was a 1929 graduate of Loyola University Stritch School of Medicine, Maywood.

****Jansen, Edward L.,** Evergreen Park, died April 12, 1988, at the age of 79. Dr. Jansen was a 1936 graduate of Loyola University Stritch School of Medicine, Maywood.

Josenhans, Ulrich H., Chicago, died April 2, 1988, at the age of 64. Dr. Josenhans was a 1952 graduate of Medizinische Fakultat Universitat Heidelberg, Baden-Wurttemberg, Germany.

***Kinsman, Ben A.,** Du Quoin, died June 4, 1988, at the age of 66. Dr. Kinsman was a 1947 graduate of the University of Illinois College of Medicine, Chicago.

****Landy, Nathaniel E.,** Chicago, died March 16, 1988, at the age of 79. Dr. Landy was a 1936 graduate of the University of Health Sciences/Chicago Medical School.

****McDaniel, L. R.,** Polo, died February 5, 1988, at the age of 87. Dr. McDaniel was a 1928 graduate of the University of Illinois College of Medicine, Chicago.

****McNamara, Edward W.,** Westchester, died January 9, 1988, at the age of 79. Dr. McNamara was a 1937 graduate of Loyola University Stritch School of Medicine, Maywood.

Shortall, James P., Chicago, died April 5, 1988, at the age of 73. Dr. Shortall was a 1941 graduate of Loyola University Stritch School of Medicine, Maywood.

Taylor, James H., Villa Grove, died January 30, 1988, at the age of 78. Dr. Taylor was a 1935 graduate of the Indiana University School of Medicine, Indianapolis. ◀

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

No significant alteration in the progression of diabetic retinopathy appeared after two years of treatment by either the conventional injection technique or the continuous subcutaneous insulin infusion technique. In diabetics with mild to moderate nonproliferative retinopathy, there was unexpected acceleration of retinopathy associated with tightened control. However, this was not sustained and did not initiate vasoproliferative deterioration in retinopathy. (The Kroc Collaborative Study Group: *JAMA* 260:1,37-41, 1988)

Seventeen patients with familial hyperlipidemia were classified type 2b (9 cases) or type 4 (8 cases) and treated randomly with either gemfibrozil and colestipol or gemfibrozil and lovastatin. Although gemfibrozil with either colestipol or lovastatin favorably altered lipoprotein levels in patients with hypertriglyceridemia and familial combined hyperlipidemia, the combination of gemfibrozil and lovastatin appeared superior overall. (East, C., et al., *Ann Int Med* 109:1,25-32, 1988)

Autopsies were performed on 237 patients 90 years of age or older. The degree and extent of coronary atherosclerosis was similar to that in younger patients who died of coronary heart disease, but calcification of the coronary arteries, mitral annulus, and aortic valve were more prevalent, as was cardiac amyloidosis. An important factor in attaining longevity seems to be protection from the development of severe coronary heart disease by an unexplained mechanism. (Lie, J., Hammond P., *Mayo Clin Proc* 63:6,552-64, 1988)

Reflex sympathetic dystrophy is characterized by burning pain, swelling, stiffness, and discoloration frequently after a painful injury. It may be associated with osteoporosis, pseudomotor changes, vasomotor instability, trophic changes, and may lead to restricted joint motion. The authors treated 20 patients with a sympathetic block technique, consisting of placement of an intravenous catheter into the involved upper extremity, exsanguinating the extremity with a bandage and tourniquet and injecting 35-45ml of 0.5% lidocaine, 1.5-2mg of reserpine or 5-10mg guanethidine, and 80-120mg of methylprednisolone. After 10-15 minutes the extremity is manipulated through the range of motion. This procedure was found especially effective in early cases, particularly in wrist and hand involvements. The more protracted cases may require repeat blocks at 48-72 hour intervals. (Duncan, K., *et al., Orthopedics* 11:6,883-6, 1988)

Thirty-six hemiplegic patients were divided into four groups for retraining. One group received the conventional physical therapy program, the second group received the addition of functional electrical stimulation to the paralytic lower extremity, the third group received biofeedback with the conventional physical therapeutic technique and the last group received physical therapy, biofeedback and functional electrical stimulation. Each patient received 30 minutes of therapy three times a week for six weeks. The combined therapy of biofeedback, functional electrical stimulation and physical therapy markedly improved knee and ankle flexion angles during the swing phase, in addition to velocity of gait, cycle time, and symmetry of stance phase. The elapsed time from onset of stroke was not a significant factor. (Cozean, C., *et al., Arch Phys Med Rehabil* 69:6,401-5, 1988)

The heart disease predictive instrument of Pozen, *et al.,* and the ECG scoring method of Brush, *et al.,* were applied and compared retrospectively to 108 patients admitted to a rural community hospital family practice service because of suspected myocardial infarction. Myocardial infarction occurred in 24 of the 108 cases (22.2%). The most valuable criteria were considered to be the seven factors composing the heart disease predictive instrument: (1) pain or pressure in chest or left arm; (2) patient's most important complaint; (3) history of myocardial infarction; (4) history of nitroglycerin use for chest pain; (5) ECG ST segment elevation or depression of 1mm or more; (6) ECG ST segment "straightening" or "barring" with <0.5mm elevation or depression; and (7) ECG T-wave inversion or hyperacuity >50% of R wave amplitude. (Green, L., Smith M., *J Fam Pract* 26:6,627-32, 1988)

Radiographic studies found the incidence of knee osteoarthritis to be markedly higher in obese people. Between the years 1983-1985, 468 subjects (33%) displayed knee osteoarthritis. The association between weight and subsequent osteoarthritis was stronger in women than men, and continued to persist despite controlled serum uric acid levels and physical activity. Incidence was highest for persons with the most severe radiographic disease, whether symptomatic or asymptomatic. (Felson, D., *et al., Ann Int Med* 109:1,18-24, 1988)

A CORNERSTONE OF SECURITY

ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE

STABLE

In an unstable professional liability climate, a stable insurance carrier is a **must**. Nearly 10,000 physicians have found a cornerstone of security in the Illinois State Medical Inter-Insurance Exchange, the state's first and largest physician-owned professional liability insurer.

The Exchange is the only carrier in Illinois which has continually offered coverage to new applicants since 1976. Our record is one of commitment to policyholders. That has sometimes meant difficult decisions, such as converting to claims-made insurance, setting realistic premiums and adhering to tough underwriting standards. That commitment—and these decisions—allowed the Exchange to stand firm when others were abandoning Illinois physicians.

AGGRESSIVE

Policyholders depend on the Exchange for aggressive defense. Claim examiners direct and monitor the legal team to see that the physician's voice is heard and that the defense is diligent, efficient and speedy. The Exchange continually audits its defense firms to enforce strict performance standards.

But, there is no better defense than prevention. The Exchange's loss prevention program helps physicians learn not only how to prevent suits, but also what steps to take for the best results once a claim or suit is filed.

COMMITTED TO THE ILLINOIS PHYSICIAN

The Exchange exists for the Illinois physicians it insures. Its priorities are diligent claim management, careful underwriting and fiscal responsibility. A commitment to long-term vision, tempered by flexibility, will ensure stability and help to keep rates down. That commitment is a cornerstone of security for Illinois physicians.

ILLINOIS STATE MEDICAL INTER-INSURANCE EXCHANGE

Illinois State Medical Inter-Insurance Exchange
Twenty North Michigan Avenue
Suite 700
Chicago, IL 60602
(312) 782-2749
(800) 782-ISMS
(Toll-Free)

DOCTOR'S NEWS

JUST A DECIMAL POINT . . .

The July "Doctor's News" incorrectly stated some data regarding Medicare administrative expenses during fiscal year 1987. The report should have indicated that:

Medicare Hospital Insurance Trust Fund (Part A) expenditures totalled $50.0 billion in 1987. Of this, $0.8 billion, or 1.7%, was spent on administrative expenses. The Medicare Supplementary Medical Insurance Trust Fund (Part B) expenditures totalled $29.9 billion in 1987, and $0.9 billion, or 3.0% of this went to administrative expenses. Overall Medicare administrative expenses were $1.7 billion or 2.1% of Medicare health care expenses.

ILLINOIS MEMBERS IN NATIONAL ROLES

John J. Ring, M.D., Mundelein, has been elected chairman of the American Medical Association Board of Trustees. Dr. Ring, a former member of the ISMS Board of Trustees and delegation to the AMA, has served as vice-chairman of the AMA Board of Trustees and is currently serving his second term on the AMA Board.

Two Illinois medical students have been named to AMA Medical Student Section positions. **William McDade,** a medical student at the University of Chicago Pritzker School of Medicine, will serve as vice-chairman of the AMA Medical Student Section Governing Council. Mr. McDade has previously served as chairman of the Chicago Medical Society Student Branch and is also an active member of the ISMS Medical Student Section. **K. Gregory Lucchesi,** a student member at Northwestern University Medical School, will serve as vice-speaker for the AMA Medical Student Section Assembly. Mr. Lucchesi is also chairman of the ISMS Medical Student Section Governing Council.

In addition, the following Illinois medical students were appointed to serve on AMA councils and as AMA representatives: **Dipali Apte** of the University of Illinois at Urbana will serve on the Liaison Committee for Medical Education; **Scott Bernstein** of the University of Illinois at Urbana will serve on the Council on Scientific Affairs; and **Robert Wolski** of the University of Illinois at Chicago will serve on the Council on Ethical and Judicial Affairs.

Two Illinois resident physicians were elected to serve on the AMA Resident Physician Section Governing Council. Elected were **Bruce Doblin, M.D.,** Chicago, as At-Large Member, and **Gail Williamson, M.D.,** Chicago, as Alternate Delegate to the AMA House. Both are active members of the ISMS Resident Physicians Section, with Dr. Doblin currently serving as the ISMS-RPS Chairman.

PHYSICIANS IN THE NEWS

Dean Schraufnagel, M.D., an associate professor of medicine and director of the Pulmonary Function Lab at the University of Illinois Medical Center, Chicago, was recently named president of the Chicago Thoracic Society . . . **Elvin Zook, M.D.,** Springfield, was elected secretary-treasurer of the American Board of Plastic Surgery and will act as its representative to the American Board of Medical Specialists. Dr. Zook is professor of surgery and chairman of the division of plastic surgery at Southern Illinois University School of Medicine . . . The Illinois Academy of Family Physicians named **Richard H. Dolan, M.D.** Illinois Family Physician of the Year for 1988. Dr. Dolan has a 30-year career of family medicine practice in Libertyville . . . **Ramesh C. Tripathi, M.D., Ph.D.** was recently honored as recipient of the 1987 Alcon Research Institute's Prize for outstanding contributions to vision research. Dr. Tripathi has also been chosen as the recipient of the India Medical Association U.S.A.'s Distinguished Physician Award.

DIABETES RESEARCH STUDY NEEDS VOLUNTEERS

Northwestern University is seeking individuals with diabetes to be a part of a National Institutes of Health clinical trial. Northwestern University is part of the Diabetes Control and Complications Trial (DCCT) which seeks to compare the effectiveness of intensive insulin treatment with the usual diabetes therapy in preventing or delaying serious complications of diabetes such as damage to vision, kidneys, nerve tissue and blood vessels.

To qualify, volunteers must be between the ages of 13-39, have had diabetes less than five years, be taking 1-2 insulin injections a day, and be free of advanced complications of diabetes. Eligible volunteers will be randomly assigned to one of two treatment groups.

The DCCT is the largest prospective, randomized study of the problem ever undertaken. The study will involve about 1,400 patients nationally in 27 centers for a five year period.

For more information contact Barbara Schaefer, R.N., M.S., Trial Coordinator, at (312) 908-5566, or use this prescreening number, 1-800-522-DCCT.

SPANISH LANGUAGE AIDS BROCHURE AVAILABLE

The Illinois Department of Public Health has published an informative brochure in Spanish answering some common questions about the required premarital blood tests in Illinois. The reader learns which tests the law requires, what they entail, who is responsible to pay and who will know the results—as well as the basics in obtaining a marriage license in Illinois. It also puts to rest a common fear that a positive HIV result will preclude the individual from receiving a marriage license. The pamphlet concludes with a brief summary of the known truths about AIDS—how you get it and how you don't—and offers more straight talk and confidential answers through their toll free number 1-800-AID-AIDS. ◀



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Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix* may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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Modern Stereotactic Neurosurgery

By Jeffrey W. Cozzens M.D., Ivan S. Ciric M.D., and Theodore W. Eller M.D./Evanston

Stereotactic neurosurgery has recently generated new interest due to the advent of brain imaging techniques, specifically, computerized axial tomography (CT) and magnetic resonance imaging (MRI). Older stereotactic devices have been modified and new devices have been designed which take advantage of this new imaging technology. Neurosurgeons now have surgical access to brain lesions with an accuracy of +/− 1mm. Lesions can be biopsied, cysts drained, electrodes placed, radiation delivered, and tissue transplanted with very low morbidity and mortality. Stereotactic neurosurgery does not replace craniotomy and gross total removal of surgically accessible lesions. However, it does allow for tissue diagnosis of lesions where gross total removal would have unacceptable neurologic morbidity.

Stereotactic surgery of the brain can be defined as surgical access to predefined areas of the brain through as small an opening in the skull as possible, with an accuracy of +/− 1mm. This method of surgery dates back to Victor Horsley at the turn of the century, when it was recognized that the brain was uniquely structured for stereotactic localization. Since the brain is located in what is essentially a fixed hollow sphere (the skull), a fixed frame of reference can be devised which allows for reproducible localization from patient to patient. In this three-dimensional space, specific X, Y, and Z coordinates can be established for almost any brain structure.

Early stereotactic devices were frames bolted to the skull in such a way that landmarks in the skull were used for reference points. The first stereotactic frame was the Horsley-Clarke frame, developed in 1908.[1] Targets were picked with the help of stereotactic atlases based upon skull reference points. This system proved adequate for many uses, but never became popular as it soon became apparent that there was too much variability in skull shape and size. Forty years ago, with the advent of contrast ventriculography, a new system was established based upon landmarks visualized in the third ventricle. Targets in the brain were again chosen with a stereotactic atlas which was then based on the anatomy of the ventricles. As before, however, applications were limited by the necessity of operating only upon those patients whose brains best matched the ones pictured in the atlases. Locations had to be confirmed electrophysiologically. Brains containing space-occupying lesions, congenital or acquired abnormalities, and atrophied brains could not be operated upon with any degree of accuracy. Procedures were limited to ablative procedures and insertion of electrodes or other devices. Ablative procedures were quite useful for treatment of Parkinson's disease before the introduction of pharmacological treatment and for various movement, pain, and functional disorders. However, acquired lesions usually could not be dealt with, since they did not appear in the atlases.

The introduction of computerized axial tomography (CT) has resulted in renewed development in stereotactic neurosurgery. The CT now creates what can be thought of as a unique personal brain atlas for each patient's brain. If the CT is obtained with a stereotactic device fastened to the patient, then a personal brain atlas is created with a coordinate system as well. Recently, several stereotactic devices have been created with this strategy in mind. We will review these devices and discuss their potential.

Method Description

CT-guided stereotactic neurosurgery requires a stereotactic frame fastened to the patient's skull as

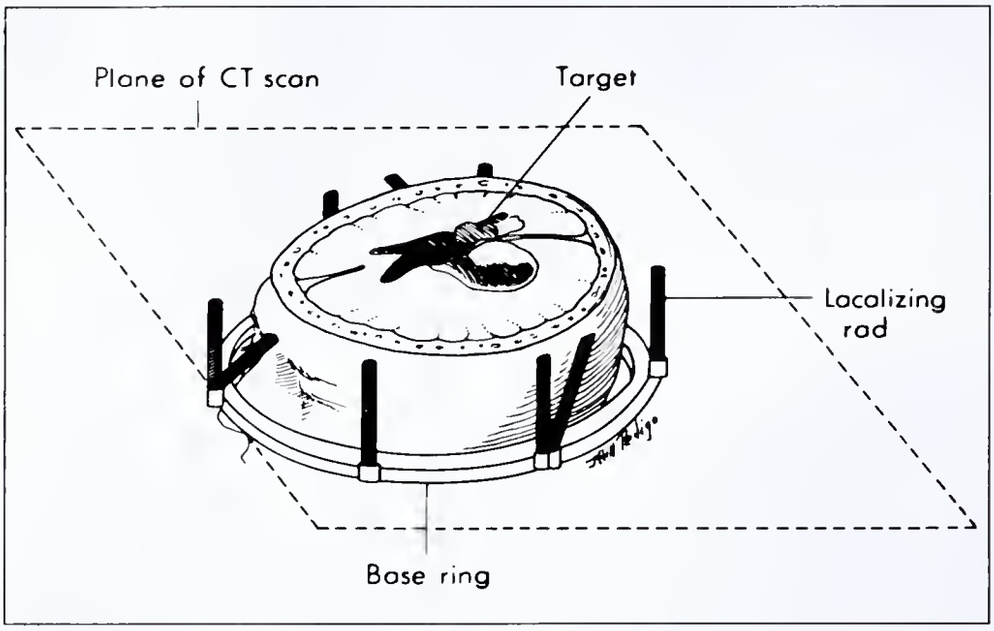


Figure 1
Illustration of imaged CT section of the brain with the stereotactic localizing ring in place, demonstrating the plane of scan, localizing rods, tumor (target) and the base ring attached to the skull as a plane of reference.

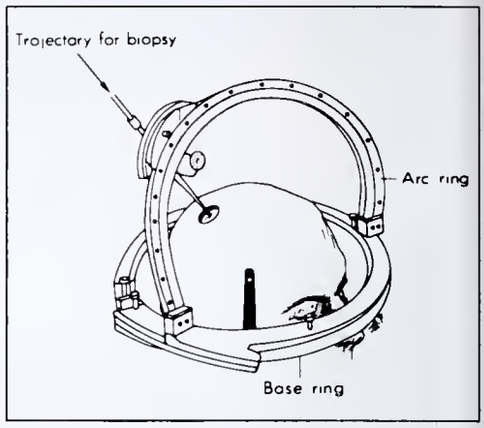


Figure 2
Illustration of a stereotactic biopsy through a burr hole with the stereotactic arc ring now in place on the base ring.

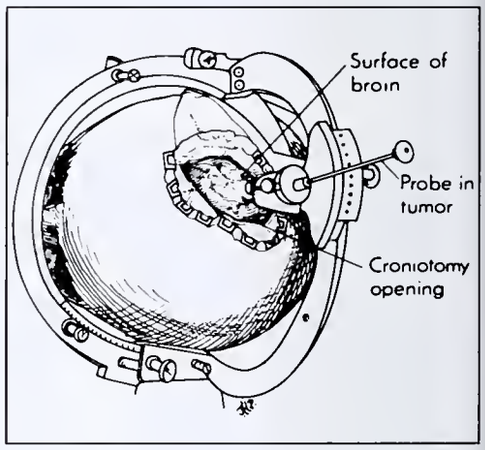


Figure 3
Illustration of the stereotactic device used during a craniotomy for precise localization of a deep brain tumor.

the CT scan is obtained. With the BRW device, a base ring is first attached to the patient's head under local anesthesia. When the CT is obtained, a localizing ring is attached to the base ring. This localizing ring has a series of parallel and oblique rods, which, when visualized on any particular CT image, determines both the height and orientation of that CT slice with reference to the base ring. (Figure 1) The positions of the nine localizing rods on the CT slice, as well as the coordinates of the target point are entered into a small personal computer. The patient is then taken to the operating room where the X, Y, and Z coordinates of an entry point through the skull are determined with the assistance of an arc frame first mounted on the base ring and then checked with a "phantom base." Coordinates are entered into the computer, which calculates new settings for the arc frame, which sets the trajectory and depth of the probe. This trajectory and depth can be reconfirmed on the phantom base before penetration of the skull is made. A small incision is made in the scalp under local anesthesia and a burr hole is made in the skull. The biopsy probe is then passed through this opening and into the brain and target. (Figure 2) If a tumor is to be biopsied, serial biopsies are usually obtained along the probe trajectory at regular intervals. If the stereotactic device is used for tumor localization, then a larger craniotomy opening is made. (Figure 3)

This method does not require any special CT equipment or positioning of the frame. With a magnetic resonance image (MRI) compatible localizing ring, surgery is possible utilizing MRI targets. The method is easily learned by any neurosurgeon. Most patients tolerate the procedure very well under local anesthesia.

Results

In a two year period between April 1985 and June 1987, forty-eight stereotactic procedures were performed at our institution. Forty-two of these were performed under local anesthesia and six were performed under general anesthesia. Of these procedures, 31 were biopsies of tumors or lesions, 12 were biopsies of tumors with associated insertion of an Ommaya reservoir into a tumor cyst, four were stereotactic localizations of tumors for craniotomy, and one was an aspiration of a bacterial abscess.

There was no mortality associated with surgery. Only one case of hemorrhage into a tumor after a biopsy occurred (this patient had a temporary hemiparesis which resolved spontaneously). Thus a surgical morbidity of 2% was achieved.

Indications for Use

Biopsy

The most common application of CT-guided stereotactic surgery today is with biopsy or aspiration of brain lesions. A biopsy is indicated when a patient has a deep-seated or inoperable tumor, or if the patient's

physical condition precludes a craniotomy for resection. In most cases, gross total resection is preferable to biopsy, but if this is unachievable, stereotactic biopsy has a lower incidence of complication than open biopsy, which requires the same exposure as with a resection. Partial resection is often associated with severe tumor swelling and edema, which is not seen with total resection.[2] This has led us to attempt gross total resection whenever possible, even in functionally eloquent areas of the brain (*i.e.*, left frontal operculum, left posterior temporal, right and left pre- and post-central gyrus). Stereotactic biopsy is utilized when the tumor invades both hemispheres across the corpus callosum, or is situated in the deep structures such as the basal ganglia, thalamus, or brain stem.

Stereotactic biopsy also has been employed in the diagnosis of lesions which could not be diagnosed definitively as neoplastic in preoperative neuroradiological or MRI studies. These lesions may or may not require further surgery, and stereotactic biopsy is a relatively low risk method of obtaining tissue for diagnosis.

Biopsies can be obtained in a serial manner at regular intervals along the probe trajectory through the tumor. This often results in a more complete tumor diagnosis than can be made with an open biopsy obtained in only one site at the tumor surface. A tumor classified as anaplastic astrocytoma with open biopsy could be more correctly established as glioblastoma multiforme with a serial stereotactic biopsy.

In our series there were no deaths and only one case of temporary neurologic deterioration following CT-guided stereotactic biopsy, for a surgical morbidity rate of 2%. This morbidity is similar to that reported by others.[3] Morbidity in these cases was usually associated with hemorrhage at the site of biopsy and rarely with mechanical damage or swelling associated with the passage of the biopsy needle. In most cases, morbidity due to hemorrhage can be avoided by obtaining a pre-operative angiogram or MRI scan to rule out vascular malformation, cavernous angioma, or an unusually vascular tumor. A trajectory chosen to avoid the sylvian fissure also will reduce the chance of piercing major vessels in this area.

In many cases, tumors are determined to be unresectible, but have a large fluid-filled cystic component which causes considerable mass effect. Decompression of this mass by drainage of the cyst can result in a temporary relief of symptoms.[4] We have drained tumor cysts in 12 patients with some degree of relief, albeit temporary, in all cases. This was accomplished by implanting a catheter into the cyst and connecting the catheter to a subcutaneous Ommaya reservoir, which periodically can be tapped percutaneously.

Localization

Since the introduction of CT scanning, it is not uncommon for small brain tumors to be found in patients scanned for minimal symptoms or for reasons unrelated to the presence of the tumor. These small tumors can present a problem in resection, especially when they lie deep to the cerebral cortex. Although the general location of the tumor may be known by the surgeon, the exact location may require some searching, resulting in unnecessary trauma to the brain with corresponding neurological morbidity. In recent years intraoperative ultrasound has helped to locate many of these lesions, but other lesions are very difficult to distinguish from the normal brain. The stereotactic device can be left in place as a craniotomy is performed and the trajectory of the biopsy probe can be followed directly to the tumor. The tumor can then be resected using the smallest incision and craniotomy possible. This would be very difficult to achieve using ultrasonic localization.

Aspiration

Cystic lesions may require aspiration for diagnosis, decompression prior to further resection, or an attempted cure. Stereotactic aspiration of pus from a lesion such as a brain abscess can provide material for culture and also set the stage for antibiotic cure with low surgical morbidity and mortality. Other lesions which occasionally can be dealt with in this manner are cysticercosis lesions and colloid cysts.[5]

Electrode Implantation

Electrodes, permanent or temporary, are implanted into the brain for recording, stimulating, or lesioning.

Recording electrodes are implanted in patients with intractable epilepsy to better characterize seizure abnormality and to identify possible electrical focus. Often scalp recordings cannot identify adequately the electrical onset of a seizure. Similarly, video EEG sometimes reveals that the patient is clinically well into the seizure before an electrical abnormality can be identified from scalp recordings. Depth electrodes placed into the temporal and frontal lobes bilaterally may help determine lateralization of the seizure focus and its location within the affected lobe. These electrodes can be left in place for up to two weeks with little risk of hemorrhage or infection.[6]

Electrodes also are implanted for chronic stimulation of deep brain structures such as periaqueductal and periventricular gray matter for persistent intractable pain. This stimulation is thought to release endogenous opiates resulting in pain relief for many patients. Chronic stimulation of deep brain structures for movement disorders can also be accomplished with some degree of success.[7]

Electrodes can also be placed temporarily into deep brain targets for the purpose of making destructive lesions in these structures. Lesions have been made for chronic intractable pain, movement disorders such as Parkinson's disease unresponsive to neuropharmacological treatment, and for control of certain psychiatric disorders which are unresponsive to medication. Lesions are created by confirming the placement of the tip of the probe both anatomically and physiologically and then coagulating the tissue with radiofrequency current.

Radiotherapy

Malignant gliomas of the brain generally have a poor prognosis,

despite treatments of surgery, radiation, and chemotherapy. These tumors are generally sensitive to radiation, but the amount which can be delivered to a tumor by conventional means is limited by the radiosensitivity of normal brain. Overt neurological deficits can be caused by radiation exposure greater than 6000 rads, therefore, this is considered to be the limit of conventional radiation teletherapy. The technique of interstitial radiation brachytherapy has recently been developed, enabling much higher doses of radiation to be delivered to a tumor. This is accomplished by inserting small pellets of radioisotopes with a limited geometry of high activity into tumors so that the tumor receives a very large dose of continuous radiation and the normal surrounding brain receives very little. These pellets can be permanent or temporary, and usually consist of ^{125}I or ^{192}Ir. The pellets are placed stereotactically in an array so that the radiation dosimetry can exactly correspond to the geometry of the tumor.

The effectiveness of this technique remains to be seen. In one study the median survival of 43 evaluable patients was 18 months after implantation, with 50% of patients remaining alive. Patients with glioblastoma had a median survival of nine months after implantation.[8] Further research with this technique, alone or concurrent with hyperthermia and chemotherapy, is required.

Tissue Transplantation

Tissue transplantation to the brain has recently been the subject of intense investigation.[9] At present, these studies are intended to correct neuroendocrinological deficits such as Parkinson's disease. Although this work is still in very primitive stages, it is occasionally performed both in animals and humans using stereotactic surgery.

Summary

The introduction of computerized tomographic scanning has revitalized interest in stereotactic neurosurgery. New techniques and devices have given neurosurgeons the ability to treat lesions and conditions previously untreatable without unacceptable morbidity. Biopsies and aspirations of lesions can be made with great accuracy and with low morbidity in patients who remain awake. Electrodes for recording or stimulation can also be placed with great facility and accuracy. Stereotactic biopsy does not replace the technique of gross total resection of operable tumors and other lesions, but does allow for tissue diagnosis when gross total resection is felt to be too dangerous. ◀

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Following Microdiskectomy

Laceration of the Abdominal Aorta and Vena Cava

By Paul H. Young, M.D./Granite City

Laceration of the abdominal aorta and inferior vena cava occurred by the anterior protrusion of a sharp cartilaginous disk fragment during an L3-L4 microdiskectomy.

A 61-year-old female who had previously undergone a standard laminectomy underwent an L3-L4 microdiskectomy. At surgery, a large ruptured disk with several free fragments of disk material was removed. The interspace was fully visualized. It was found to be partially collapsed and filled with degenerative material. At no time was the anterior border of the interspace perforated by an instrument and no hemorrhage through the interspace was seen. The patient's operative blood loss was no more than 350cc.

Immediately following surgery, the patient suffered retroperitoneal hemorrhage. Laparotomy revealed a sharp fragment of cartilaginous disk material embedded between the abdominal aorta and vena cava, partially tamponading puncture wounds of both vessels. (Figure 1)

Discussion

Retroperitoneal hemorrhage from injury to retroperitoneal vessels is a serious but well-recognized complication from lumbar laminectomy and diskectomy.[1-5] Recognition of this complication is frequently delayed by the lack of immediate hemorrhage or shock.[6] The method of laceration in most instances is thought to be perforation by a sharp instrument across the anterior diskal ligaments, with direct injury of vascular struc-

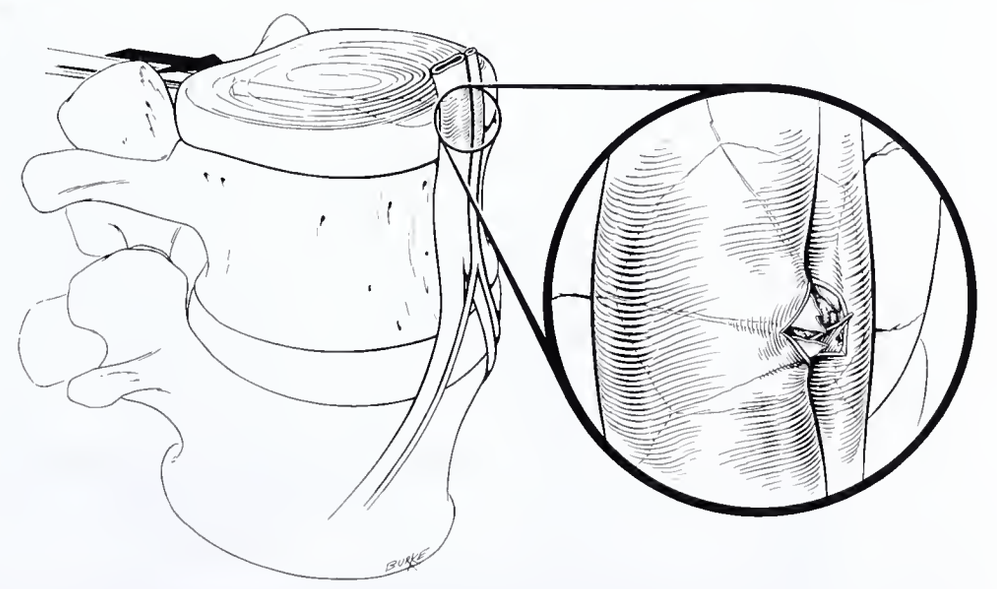


Figure 1
Laceration of aorta-caval structures by the protrusion of a cartilaginous diskal fragment during intradiskal instrumentation.

tures.[7-9]

In the present case it was possible to clearly visualize the interspace, and at no time was the retroperitoneal space entered by an instrument. Similarly, no hemorrhage into the disk space was observed. It seems likely that the forceful protrusion of a sharp diskal fragment, and not direct instrument injury, resulted in the aorta-caval laceration. No significant immediate hemorrhage was produced in this instance, as the offending disk fragment partially tamponaded the punctured vessels. ◀

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Unsuspected Bilateral Ureteral Transitional Carcinoma

By Daniel J. Culkin, M.D., John S. Wheeler, Jr., M.D., and John R. Canning, M.D./Maywood and Hines

A patient with invasive transitional cell carcinoma of the bladder had unsuspected bilateral ureteral involvement of the entire ureters which was diagnosed by frozen section during radical cystectomy. A review of this rare entity and a discussion of the intraoperative and postoperative therapeutic options, one using postoperative endourologic staging, are presented.

Bilateral ureteral involvement of tumor associated with invasive transitional cell carcinoma (TCC) of the bladder is uncommon.[1-5] Unsuspected complete ureteral involvement by carcinoma is rarer still.[6] The following case of carcinoma completely involves both ureters and was unsuspected on the precystectomy intravenous urogram. The intraoperative and postoperative therapeutic options are discussed, especially in light of newer endourologic techniques which have been developed to monitor upper urinary tract tumors.

Case Report

A 58-year-old man was admitted with intermittent painless gross hematuria of one month and an inability to void for six hours. He had a history of alcohol abuse, 60 pack year history of smoking, but no prior surgery. On examination the patient appeared pale, cooperative and coherent, and had a palpable bladder.

Initial laboratory studies revealed anemia, an elevated white blood cell count, and gross hematuria with clot retention. A catheter was placed and the bladder was drained of 800cc of grossly bloody urine. Intravenous urogram demonstrated normal upper tracts and a radiolucent bladder filling defect. Cystoscopy revealed multiple superficial tumors over the left posterolateral bladder wall sparing the ureteral orifice. Histology was a superficial, moderately-differentiated (Grade II/III) transitional cell carcinoma involving the submucosa (Stage A). Subsequently, a quarterly surveillance cystoscopy revealed recurrent tumor at the left posterolateral bladder outlet and the posterior bladder wall. Repeat resection again showed a Stage A, Grade II/III transitional cell carcinoma. A second surveillance cystoscopy revealed recurrent tumor involving the entire posterior bladder wall, the anterior bladder wall, and several areas along the bladder neck. Histology of the specimen revealed tumor cells penetrating the lamina propria and also a few areas of poorly differentiated (Grade III/III) transitional cell carcinoma. Metastatic workup, including an intravenous urogram (Figures 1A and 1B), whole lung tomograms, bone scan, liver function studies, and pelvic computerized axial tomography and bimanual exam under anesthesia revealed local disease only.

After 2000 rads of preoperative radiation, the patient underwent pelvic lymphadenectomy and radical cystectomy. Frozen sections of the pelvic nodes were negative for metastases and a radical cystectomy was uneventful. The distal ureteral specimens, although grossly negative, revealed cancer bilaterally on frozen section. Subsequent proximal ureteral specimens were sent for frozen section. Although grossly negative, multiple frozen sections revealed that both ureters were involved with a submucosal sheet of transitional cell carcinoma along most of their length. Both ureters were resected to the level of the ureteropelvic junctions and bilateral nephrostomy tubes were placed, even though there was still microscopic submucosal tumor at both pelvic margins. It was elected at this

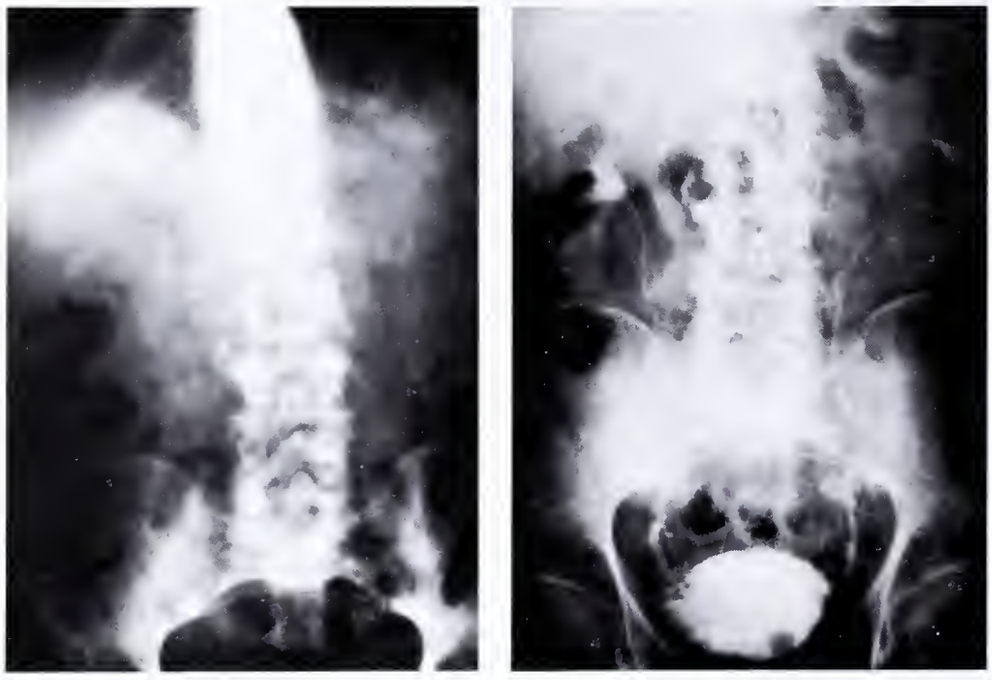


Figure 1A and B
A scout and 15-minute film of an intravenous urogram demonstrating normal ureters.

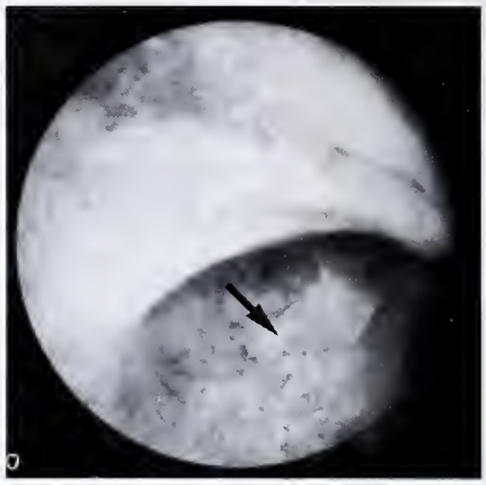


Figure 2
Nephroscopic picture of left kidney with papilla marked by an arrow.

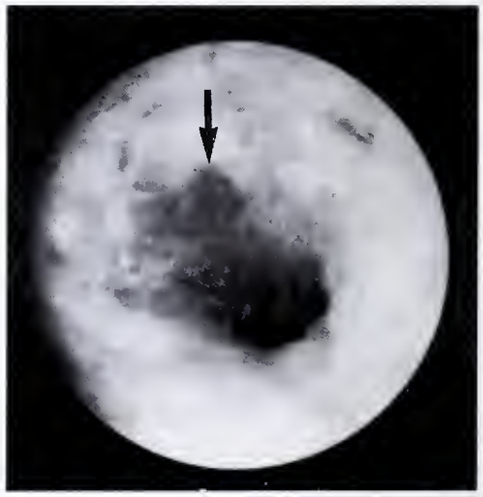


Figure 3
Nephroscopic picture of left kidney showing superior pole infundibulum. Arrow marks area of biopsy.



Figure 4
Nephroscopic picture of right kidney collecting system. Arrow marks area of biopsy.

point to cease any further surgery and allow the patient to decide as to further radical surgery with possible hemodialysis, or conservative follow-up with surveillance nephroscopy and possible endoscopic intrarenal surgery.

In the postoperative period the patient refused further open radical surgery, but did agree to percutaneous nephroscopy and possible intrarenal surgery. Twelve weeks following surgery the patient was nephroscoped through the nephrostomy tracts. (Figures 2-4) No evidence of tumor was seen on random biopsy. Subsequent to this hospitalization the patient was uncooperative and lost to follow-up. He was rehospitalized approximately three months later, but refused further therapy. His nephrostomy tubes became dislodged and he refused to have them replaced. Our patient died of electrolyte abnormalities approximately six months after his radical cystectomy, without any discernible clinical evidence of cancer. A postmortem examination was not obtained.

Discussion

Urothelial transitional cell tumors can be multicentric in origin. For example, approximately 10% of patients have carcinoma *in situ* of the distal ureter detected during routine cystectomy for bladder cancer.[7] However, unsuspected complete involvement of one or both ureters by carcinoma is very unusual. Culp reported close to a 15% incidence of ureteral tumor in 231 patients with vesical neoplasms.[6] Frozen section at surgery was the only means of diagnosis, indicating the need for further ureteral resection.[6] In this large series, all histologic patterns were encountered, although the patients with high-grade infiltrating neoplasms had a higher incidence of ureteral involvement.[6] Nine patients displayed complete unilateral ureteral involvement requiring adjuvant nephroureterectomy, with most of the cases having distal ureteral involvement only.[6] One case only was seen with carcinoma up to the ureteropelvic junction.[6] Additionally, there were six cases of bilateral distal ureteral involvement by tumor in this series, but no cases reported of bilateral complete involvement of tumor in both ureters, as was the case with our patient.[6]

There also have been several reports of bilateral synchronous transitional cell ureteral carcinoma

associated with subsequent development of TCC in the bladder.[1-5] However, these reports are of ureteral cancers that were radiologically evident, as opposed to our case, in which the preoperative urogram was negative and the tumors were unsuspected.

Our case illustrates several key urologic points. First, frozen section of the distal ureter during cystectomy is important, even with a negative preoperative urogram. Although bilateral unsuspected synchronous ureteral tumor is rare, its presence may alter the surgical procedure by requiring further ureteral resection prior to ureteroileal anastomosis, or possibly nephroureterectomy, if the total ureter is involved.[6,7] With both ureters entirely involved, the therapeutic options become challenging. Without patient or family consent for bilateral nephrectomy, we placed bilateral nephrostomy tubes during surgery, with the idea of future staging and radical surgery after obtaining proper consent. However, bilateral nephroureterectomies would be a legitimate option because of the potential surgical curability of this disease, and the fair lifestyle that dialysis can now provide.

With the recent addition of endourology in managing urothelial lesions, urological diagnostic and therapeutic capabilities have expanded greatly. Using our patient's nephrostomy tracts, we staged our patient postoperatively with percutaneous nephropyeloscopy and random biopsies. (Figures 2-4) Both the observation nephroscopy and the biopsies were negative for tumor. Why this workup was negative, in the face of positive ureteropelvic junction margins at surgery, is not clear. Either the patient was tumor free or the nephroscopic biopsies were inadequate and bypassed the areas of possible tumor. Transitional call carcinoma can spread via the submucosa, leaving "skip" areas, and may be missed on random biopsy. This tumor can also be missed by routine observation endoscopy. Nevertheless, our patient was lost to followup and refused further evaluation. However, if longterm nephroscopy and biopsy continued to show no evidence of tumor we would have considered a bilateral pyeloileal loop construction to rid him of the nephrostomy tubes.[8]

Urothelial cancer continues to be a challenge, as evidenced by our case, with many unusual and rarely seen presentations requiring many therapeutic decisions. The advent of endourologic techniques has increased our armamentarium to deal with these therapeutic options, especially when faced with unusual and unsuspected upper urinary tract pathology. ◀

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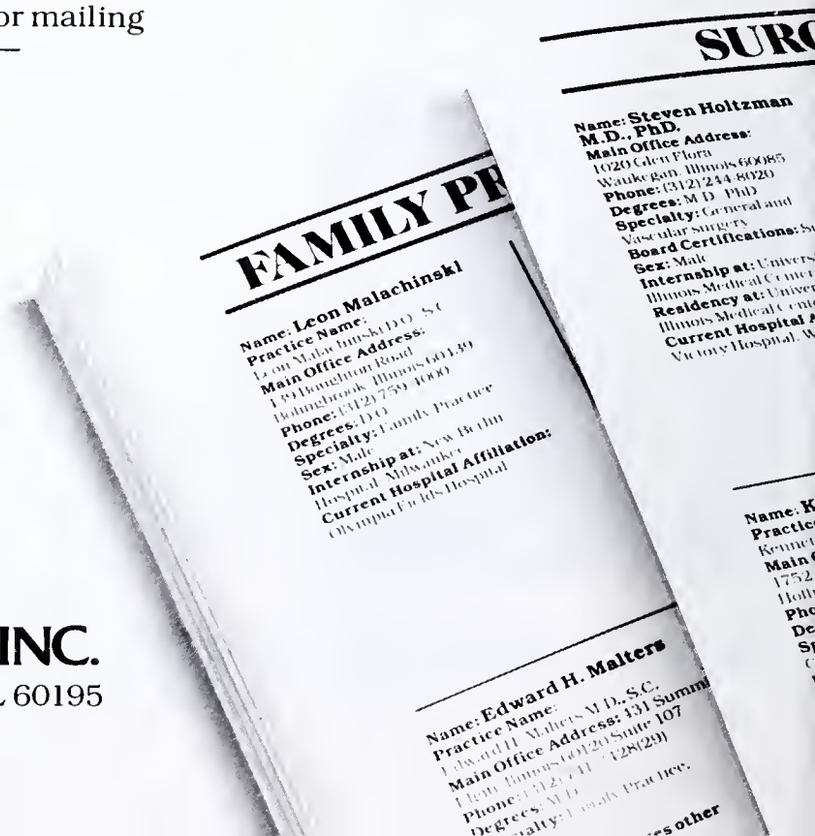
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Congenital Left Atrial Aneurysm

By Michael Borts, M.D., H. Weston Moses, M.D., Nancy Khardori, M.D., Henry Rohs, M.D., and Edward Euler, R.D., M.S./Springfield

Left atrial aneurysm (LAA) and left atrial appendage aneurysm (LAAA) are rare, congenital cardiac anomalies. We describe a patient presenting with atrial arrhythmia, who was diagnosed as having left atrial aneurysm on echocardiography. This patient has been treated medically and had done well for 24 months prior to this writing.

A 59-year-old man presented with a 20-minute episode of anterior chest pain, dyspnea and diaphoresis which resolved spontaneously. He had experienced similar episodes one week and approximately two years prior to this presentation. Physical cardiac examination was normal. ECG revealed atrial flutter with an atrial rate of 240/min and 2:1 block. Chest x-ray demonstrated nonspecific cardiac enlargement.

Echocardiography was performed and revealed an enlarged left atrium and a large echo-free space in continuity with the left atrium and extending behind the left ventricle, diagnostic of LAA. There was no evidence of intracavitary thrombus. A CT scan of the chest and esophagram excluded contiguous cystic abnormalities. Cardiac catheterization was performed because of chest pain suspicious for angina. Intracardiac pressures were normal, and no intracardiac shunt was present. Left ventricular function was normal. There was no evidence of coronary artery disease, and an ergonovine test was negative.

The patient was treated with digoxin and quinidine to maintain sinus rhythm. Crystalline warfarin sodium was added to reduce the risk of systemic emboli. He was in good health 24 months after medical therapy.

Discussion

Aneurysms of the left atrium have been assumed to be of congenital origin. They are also quite rare: 38 cases are described in the literature. They may involve the left atrial wall or, more commonly, the left atrial appendage. Signs, symptoms and complications of LAA and LAAA are the same.

As described in previously reported cases, the usual presenting abnormalities include: (1) an abnormal heart shadow on chest x-ray; (2) supraventricular arrhythmias; and (3) systemic embolization.

Diagnosis may be established by several means. The abnormal findings on chest x-ray are nonspecific. Foale, *et al.*,[1] described the radiograph to generally show cardiomegaly or a prominent convexity at the left basal aspect of the cardiac silhouette. Aneurysms from the body of the atrium may be perceived as an anterior or posterior mediastinal mass. Robinson, *et al.*,[2] found 2-D echocardiography to be the most accurate method of diagnosis, more accurate than cine angiography. De Feyter, *et al.*,[3] used radionuclide angiography to identify LAAA in six cases. The emergence of MRI may add to our diagnostic capability.

Recognition of LAA and LAAA is important because of complicating supraventricular arrhythmias and thromboemboli. Rupture has not been reported.

Although the aneurysm is believed to be congenital in nature, most patients do not present until the second to fourth decades of life.[4] Only one-third of patients present before age 10. It is postulated that the aneurysm slowly enlarges over a long period and that stasis in the atrium predisposes to thrombus formation with subsequent embolization.

According to the reports in the literature, most patients have been

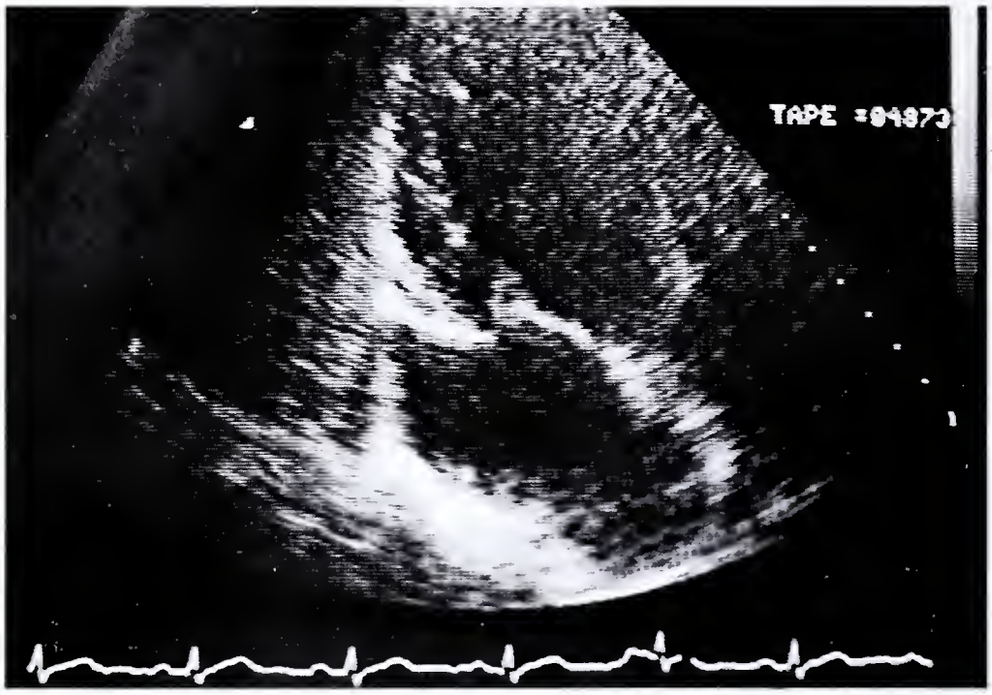
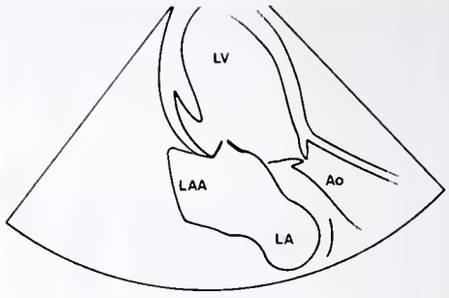


Figure 1:
Two dimensional echocardiogram from the apical long axis view showing an aneurysm of the left atrium extending behind the left ventricle.



A single frame of the 2-D echocardiogram demonstrates the left atrial aneurysm extending behind the left ventricle. This is a somewhat skewed long axis view. The aneurysm could be detected in multiple views. AO = aorta; LA = left atrium; LAA = left atrial aneurysm; and LV = left ventricle.

treated surgically. Surgery was offered this patient, but he preferred medical therapy. Since the major complications are arrhythmia and thromboembolism, the patient was treated with antiarrhythmic drugs to maintain sinus rhythm, and warfarin therapy. The patient is feeling well and was asymptomatic 24 months later at this writing. Because this disease is extremely rare, no controlled trials comparing medicine to surgical therapy may ever be done. Case report follow-up may provide guidelines as to whether surgery is necessary.

Acknowledgements

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Ciguatera Fish Poisoning

By Russell H. Glantz, M.D., and Robert B. Wright, M.D./Chicago

Ciguatera poisoning is a gastrointestinal and neurological syndrome which can be acquired from eating certain fish in the Caribbean and South Pacific. On return to the United States, the patient's symptoms may be puzzling and bizarre. We report three cases of ciguatera poisoning and discuss the features of this generally benign condition.

Ciguatera fish poisoning is a gastrointestinal and neurologic syndrome arising from the consumption of reef fish. It is a well-recognized cause of morbidity in the Caribbean and South Pacific.[1] Many people travel to these areas and may be at risk. On return to the United States, symptoms may seem bizzare and puzzling to those unfamiliar with the syndrome. We will highlight the case histories of three Illinois travelers who returned home with ciguatera poisoning after vacationing in the Caribbean, including the first case reported to health authorities in Illinois.

Case One

A 49-year-old woman who had a grouper fish dinner while vacationing in the U.S. Virgin Islands developed severe nausea and vomiting six hours after eating. This was followed shortly thereafter by watery diarrhea. She required intravenous rehydration in a St. Thomas emergency room, where she was told not to worry and that her symptoms were a common occurrence. The G.I. symptoms cleared in 24 hours but she felt fatigued. Approximately 36 hours after the onset of symptoms she noted tingling and numbness around her mouth and in her feet and hands, and felt the need to brush her teeth every couple of hours because her teeth and gums felt abnormal. She also noted a "fizzy" feeling inside her mouth, tongue and throat when drinking cold liquids. Hot and cold felt different, though not reversed. She had a mild stiff neck which lasted a few hours. In addition, her knees felt achy and there was some low back discomfort. She denied dysphagia or respiratory symptoms. The woman returned to Chicago and was seen about a week after her first symptoms. Examination revealed that she was afebrile. Vital signs were normal. General examination was normal. Her motor strength was normal; reflexes were brisk throughout. She had reduced pin sensation in her fingers and feet and vibratory sensation was reduced in her feet. Despite subjective sensory disturbance in her mouth, there were no objective findings.

Nerve conduction velocities in the arms and legs were normal. She was observed in the hospital for 48 hours.

Her symptoms gradually dissipated over four months, during which time she was treated symptomatically with antihistamines.

Case Two

A 56-year-old man had a sea bass dinner in the Dominican Republic. Eight hours later he had vomiting and diarrhea. Within hours his hands, feet, body and pubic area began to itch. He noted a "strange" sensation in his mouth and tongue. Water tasted as though it was carbonated. Except for mild persistent diarrhea, his G.I. symptoms cleared, but he was left with severe uncomfortable itching. He returned to Illinois a few days later and was evaluated six days after onset of symptoms. General physical examination was normal. Deep tendon reflexes were reduced throughout. Pin sensation was reduced in the fingers. Nerve conduction velocities were normal. Antihistamines were prescribed for the itching.

Case Three

A 56-year-old woman (wife of case two) also consumed a dinner of

sea bass. Her vomiting and diarrhea began about five hours after ingestion and she simultaneously noted the onset of hand paresthesias. The next morning she noted itchy feet, pubic tingling, itching, and a tingly tongue. Upon return to Illinois a few days later, she noticed that hot and cold felt different. Examination six days after onset revealed normal reflexes and reduced pin sensation in the hands. Nerve conduction velocities were normal. Antihistamines were prescribed.

Discussion

The *Dinoflagellata gambierdiscus toxicus* species has been identified as the source of the toxin.[2] This toxin-producing dinoflagellate is thought to be consumed by small reef fish which are in turn consumed by larger fish. The toxin accumulates in the tissues of various fish as it moves up the ocean food chain. Larger fish, therefore, are more likely to be toxic. Over 400 species of fish have been incriminated[3] but barracuda, red snapper, grouper and sea bass are usually responsible. The toxin is stable to the action of heat, cooking and gastric juice[4] and the exact mechanism by which it causes neurologic symptoms is unknown.

Most patients develop symptoms within 12 hours of ingestion.[2] The earliest manifestations in 50% of patients are diarrhea or vomiting.[5] Fever, sweats and bradycardia may accompany the G.I. symptoms and musculoskeletal pains are common.[6] Neurological symptoms are usually quite striking and may become manifest within minutes to hours of eating the fish. Dysesthesia of the mouth, gums, tongue and distal extremities may occur. Non-carbonated drinks may seem carbonated and patients may complain that their teeth feel loose or painful. In addition, various combinations of pruritis, arthralgia, headache, chills, ataxia, tremor, neck stiffness, watery eyes and rash may occur. Some patients complain of temperature reversal, *i.e.,* cold objects feel hot or painful. In more severe cases bradycardia, hypotension and respiratory paralysis can occur.[2] Although the neurologic symptoms usually last for days, they may be present for months. Because no laboratory tests are available to identify the toxin in the poisoned patient, clinical diagnosis must suffice.[6]

There is no known antidote. In the acute stage, the only treatment is respiratory support for those rare cases with respiratory paralysis. Atropine sulphate may alleviate bradycardia, but has no effect on musculoskeletal or neurologic symptoms.[6] Antihistamines or cold showers can provide symptomatic relief from itching. Amitriptyline 25mg/bid, has been recommended for pruritus and dysesthesia.[7] Based on a laboratory study suggesting that ciguatoxin is a cholinesterase inhibitor, pralidoxime has been advocated. However, later studies indicated that this is probably not true, and the use of pralidoxime is not routinely recommended.[5]

The Illinois practitioner is likely to be faced with a patient whose G.I. symptoms have subsided, but whose remaining complaints are mainly neurologic. Awareness of the disease and of its generally benign course may alleviate the fears of the patients and prevent unnecessary hospitalization and overly extensive diagnostic evaluation. ◀

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AMAA Annual Meeting

By Nancy Hoffmann (Mrs. Raymond), ISMSA President-Elect

The 1988 Annual Meeting of the American Medical Association Auxiliary was held June 26-29. National President Betty Szewczyk, of Illinois, addressed the 340 delegates in attendance and reviewed her term of office. Mrs. Szewczyk had challenged the county and state auxiliaries at her inauguration to:

- support the medical family in times of need;
- help the medical profession sustain quality medical care through teamwork with county and state medical societies; and
- impact on the health of our nation's youth.

Mrs. Szewczyk's challenge was enthusiastically accepted, as was evidenced by state presidents' speeches on subsequent days. Over 1,000 programs to help educate adolescents had been developed and implemented in the past year. Mrs. Szewczyk and twenty state representatives participated in the White House Conference on a Drug Free America, where AMAA was recognized as one of 17 organizations doing excellent educational work. County and state auxiliaries have developed support groups for physicians and families to help them cope with the stresses of medicine.

We in Illinois salute Betty Szewczyk for a job well done and take pride in the excellent leadership our state has provided to the AMAA.

The meeting's keynote address was delivered by Surgeon General C. Everett Koop, who presented two important areas of concern to the health of all citizens—AIDS and tobacco. The Surgeon General has made a great deal of headway in his efforts to promote a smoke-free America. His 1982 report on the link between cancer and smoking focused attention on this major health problem. This latest report on the addictive aspects of smoking underscores the importance of anti-smoking education for our young people.

The Surgeon General compared and contrasted the problems of AIDS and tobacco. He stressed that while AIDS victims deteriorate more rapidly, both shorten lives. People must be educated to their dangers. Dr. Koop stressed that the United States is a leader in AIDS research, both here and abroad, and has set up an excellent model for AIDS reporting. Only through explicit sexual education can we hope to achieve the impact needed to stop this epidemic, Dr. Koop emphasized.

The following resolutions were passed:

1. Continue to encourage members to work together with their local and state medical societies to promote individual communication with local, state and national lawmakers on legislative health care issues;
2. Actively support programs that educate children about the dangers of using tobacco;
3. Actively support programs promoting cholesterol testing with evaluation by a physician;
4. Encourage state and county auxiliaries to establish or continue support services that will help physicians' families cope with the stress of medical life;
5. Continue to take a strong stand to eradicate drug abuse through programs and projects which promote alcohol and drug abuse awareness, education, and prevention; and
6. Encourage state and county auxiliaries to participate in programs to increase public awareness of the dangers of passive smoking.

Newly installed President Mary Strauss, of Maryland, challenged the delegates to renew their commitment to Auxiliary because of its unlimited potential to effect the quality of life for patients and to portray to the public the compassionate concern we have for medical care. She stressed that while auxilians need to be a calming voice as the medical community faces growing ethical and legal changes, we must channel our energy into action. The many problems that the medical community has faced have created a closer bond among auxilians. The Auxiliary will continue to promote the development of new leaders, health education, fundraising activities and support of adolescent health concerns. We must remember that every physician's spouse deserves the opportunity to be a member, and we must work one-on-one to share this opportunity with them. With renewed commitment, the potential of our county, state and national Auxiliary federation is unlimited. ◀

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Ophthalmology, Neurology, Radiology
Clinical Neuro-Ophthalmology Symposium
For: Ophthalmologists, neurologists, and radiologists. Symposium, Sept. 9-10, The Wisconsin Center, Madison, WI. **Sponsor:** UW-Madison, CME and the Depts. of Ophthalmology and Neurology, School of Medicine, UW-Madison, 2715 Marshall Court, Madison, WI 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; UW CEH's: 7 hours. **Contact:** Cathy Means. **Phone:** (608) 263-6637.

Psychiatry
The Psychiatric Interview
For: Psychiatrists. Course, Sept. 23-25, Chicago, IL. **Sponsor:** University of Chicago School of Medicine, Center for CME, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** $375. **Reg. Limit:** 200. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

October

Cardiology
Balloon Application in Cardiovascular Medicine
For: Cardiologists, Internists, Family Practitioners, Physicians-in-Training and Nurses. October 29, Peoria, Illinois. **Sponsor:** The Methodist Medical Center of Illinois, 221 N.E. Glen Oak Avenue, Peoria, IL 61636. **Fee:** $40. **Reg. Limit:** None. **Credit:** Category 1: 5 hours; AAFP Prescribed: TBD. **Contact:** Jerelyn Blackburn. **Phone:** (309) 672-4895.

Cardiology, Orthopedics, Sports Medicine
Symposium on Cardiac Rehabilitation and Orthopaedic and Sports Injuries
For: MDs, RNs, PTs, OTs. Workshop and symposium: October 18-21, La Crosse, WI **Sponsors:** La Crosse Exercise and Health Program and the Wisconsin Heart Institute, 221 Mitchell Hall, University of Wisconsin-La Crosse, La Crosse, WI 54601. **Fee:** before September 6: $275 for workshop and symposium; $225 for symposium only; after September 6: $350 for workshop and symposium; $275 for symposium only. **Reg. Limit:** workshop: 25; symposium: none. **Credit:** Category 1: workshop—8 hours; symposium—20 hours. **Contact:** Patricia L. Hutchinson. **Phone:** (608) 785-8686.

Dermatology
Day of Learning: "Skin Signs of Systemic Disease" and "Newer Aspects of Contact Dermatitis"
For: Dermatologists. Lectures: October 5, Evanston, IL. **Sponsor:** Great Lakes Dermatological Society, 2324 W. Peterson Avenue, Chicago, IL 60659. **Fee:** $60 for practicing physicians; $20 for residents. **Reg. Limit:** 100. **Credit:** Category 1: 6 hours. **Contact:** Silas Wallk, M.D. **Phone:** (312) 973-2666.

Internal Medicine
Specialty Review in Nephrology
For: Nephrologists and internists. Lecture: October 10-14, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 521-4651 (outside Illinois).

Specialty Review in Rheumatology
For: Rheumatologists and internists. Lecture: October 3-7, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Current Clinical Neurology: A Comprehensive Review
For: Neurologists, psychiatrists, and neurosurgeons. Lecture: October 24-28, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $570. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Nuclear Medicine, Radiology
Forecast for the 1990's—Practical Advances in Nuclear Medicine
For: Physicians and technologists. Seminar: October 15-16, 1988, Rosemont, IL. **Sponsor:** Society of Nuclear Medicine, Central Chapter, 2321 Fourth Street, Suite 111, Tucker, GA 30084. **Fee:** nonmember MD: $110; nonmember technologists: $75; residents and technology students: $30; discount for Central Chapter members. **Reg. Limit:** none. **Credit:** Category 1: 10.4 hours. **Contact:** Dennis Park. **Phone:** (404) 493-4524.

Obstetrics and Gynecology
Specialty Review in Obstetrics and Gynecology: Practical Aspects
For: Obstetricians and gynecologists. Lecture: October 16-22, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $715. **Credit:** Category 1: 55 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Pathology
Advances in Anatomic and Clinical Pathology
For: Pathologists. Lecture: October 16-21, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $630. **Credit:** Category 1: 51 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Pediatrics, Family Practice
Seminar in Pediatrics
For: Physicians and other interested health professionals. Conference: October 28-29, Madison, WI. **Sponsor:** University of Wisconsin, Continuing Medical Education and Dept. of Pediatrics, University of Wisconsin School of Medicine, 2715 Marshall Court, Madison, WI 53705. **Fee:** TBA. **Credit:** Category 1: 10 hours; AAFP: 10 hours pending; AOA Category 2-D: 10 hours. **Contact:** Cathy Means, Program Coordinator. **Phone:** (608) 263-6637.

Psychiatry
Multiple Personality/Dissociative States
For: Psychiatrists, nurses, social workers. Lecture/workshop: October 6-9, Chicago, IL. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, Office of Continuing Education, 600 S. Paulina, Chicago, IL 60612. **Fee:** $245. **Credit:** Category 1: 25 hours; APA: 24 hours. **Contact:** Continuing Medical Education. **Phone:** (312) 942-7095.

Pulmonary Diseases
Second Annual Weekend Refresher in Pulmonary Diseases
For: Primary Care Physicians. Practical review with lectures and case oriented discussions, October 14-15, Galena, IL. **Sponsor:** The University of Illinois College of Medicine at Chicago, Dept. of Medicine, Section of Respiratory and Critical Care Medicine, 912 S. Wood Street, (m/c 607), Chicago, IL 60612. **Fee:** $195. **Reg. Limit:** 120. **Credit:** Category 1: 10 hours applied for; AAFP Prescribed: 10 hours applied for. **Contact:** Sue Talbert. **Phone:** (312) 996-4631.

Surgery
Specialty Review in General Surgery, Part II
For: General and specializing surgeons. Lecture: October 3-14, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $880. **Credit:** Category 1: 103 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

November

General Practice, Internal Medicine
Coronary Heart Disease: Current Concepts
For: General practitioners, internists. Lecture/workshop: November 11-12, Chicago, IL. **Sponsor:** Medical Education Resources, 5808 South Rapp Street, Suite 202, Littleton, CO 80120. **Fee:** $295. **Reg. Limit:** 40. **Credit:** Category 1: 11 hours; AAFP prescribed: 11 hours. **Contact:** Deborah Wilderson. **Phone:** (800) 421-3756 (outside Colorado); (303) 798-9682 (in Colorado).

Hematology/Oncology
Antidote to Adjuvant—The Changing Role of Leucovorin in Clinical Oncology
For: Hematologists and oncologists. Symposium: November 9, Chicago, IL. **Sponsor:** The University of Chicago School of Medicine, Center for Continuing Medical Education, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 3 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Neurology
Neuroimmunology VI
For: Neurologists. Course: November 3-5, Chicago, IL. **Sponsor:** The University of Chicago School of Medicine, Center for Continuing Medical Education, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** 100. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Ophthalmology
Glaucoma Management for the 90's
For: Ophthalmologists. Conference: November 4-5, Chicago, IL. **Sponsor:** UIC College of Medicine, Dept. of Ophthalmology, 912 S. Wood Street, 2nd Floor North (m/c 607), Chicago, IL 60612. **Fee:** $250. **Reg. Limit:** 200. **Reg. Deadline:** October 21. **Credit:** Category 1: 10 hours. **Contact:** Sue Talbert. **Phone:** (312) 996-4631.

Laser for Common Fundus Diseases: A Workshop on the Why, When, and How of Treatment
For: Ophthalmologists. Workshop: November 18-19, Madison, WI. **Sponsor:** University of Wisconsin-Madison, Continuing Medical Education and Dept. of Ophthalmology, 2715 Marshall Court, Madison, WI 53705. **Fee:** TBA. **Reg. Limit:** 50. **Credit:** Category 1: 17 hours. **Contact:** Cathy Means, Program Coordinator. **Phone:** (608) 263-6637.

Phacoemulsification Workshop
For: Ophthalmologists. Lecture/wet lab: November 5, Chicago, IL. **Sponsor:** UIC College of Medicine, Dept. of Ophthalmology, 912 S. Wood Street, 2nd Floor North (m/c 607), Chicago, IL 60612. **Fee:** $100. **Reg. Limit:** lecture: none; wet lab: 50. **Reg. Deadline:** October 21. **Credit:** Category 1: 4 hours. **Contact:** Sue Talbert. **Phone:** (312) 996-4631.

Exchange Insights

August, 1988

ON MALPRACTICE PREVENTION

The Board of Governors of the Illinois State Medical Inter-Insurance Exchange presents "Exchange Insights on Malpractice Prevention" as a service to Illinois State Medical Society members and Exchange policyholders. This monthly feature is designed to educate physicians on those areas in their practice which have the potential for causing claims, and to offer possible ways to minimize risks. **Exchange Insights** *may be removed and kept with your other important Exchange professional liability information.*

The following is excerpted with permission from Trial *(June, 1988), copyright 1988, The Association of Trial Lawyers of America. It was written by Diane Acker Nygaard and Sara J. Deubner, two plaintiff attorneys who specialize in medical negligence litigation. The article demonstrates how altered or destroyed medical records can undermine a physician's defense, and the degree to which plaintiff attorneys try to uncover that an alteration has been made.*

Altered or 'Lost' Medical Records— Detecting the Problem and Obtaining Relief

Desperate people do desperate things, and a physician who believes he will be sued for negligence is desperate. Few defendants have greater control over the body of evidence that will form the basis for a suit: physicians usually have unfettered access to their patients' medical records. Having both motive and opportunity, some physicians and other health-care professionals, unfortunately, may be tempted to alter or destroy medical records that support negligence cases against them. It is the job of the plaintiff's lawyer to prevent this or to discover an alteration that has been made.

Prevention and Detection

Because the risk of altered records is great, the resourceful plaintiff's lawyer gets all records quickly, often asking the client to get them personally, rather than requesting that they be sent to the attorney's office. A physician reacts to an attorney's request by personally reviewing the file. This invites changes if the records do not reflect what the physician wishes they did.

The original records should be reviewed to make sure they are complete and unaltered. For example, radiologist's reports and x-ray films should match up and office notes should be on identical forms and follow in chronological order.

Often, insurance forms will provide a complete list of tests or procedures performed, which may not appear elsewhere in expurgated records. Examining the original records can reveal clues to alterations, including:

☐ Writing crowded around existing entries;
☐ Changes in slant, pressure, uniformity, or other differences in handwriting;
☐ Erasure or obliteration;
☐ Use of different pens or typewriters to write one entry;
☐ Misaligned typed notation;
☐ Impressions or lack of impressions from writing instruments on the following page;
☐ Ink offsets or lack of offsets on the back side of the preceding page; and
☐ Additions on different dates written in the same ink, while original entries were written in a different ink.[1]

Clues to substituted or rewritten records include:

☐ Unnatural order of writing and uniformity of handwriting, ink, margins, and spacing;
☐ Intersecting fountain pen entries of different dates that bleed together;
☐ Differences between pages as to folds, stains, offsets, impressions, holes, tears, and type of paper used;
☐ Use of forms not in use at the purported time of entry; and
☐ Use of later year (1988 for 1987), especially if it has been corrected several times.[2]

The content of records may suggest spoliation. In a recent case,[3] the plaintiff died from undiagnosed endocarditis. The medical records reflected the plaintiff's brother had died from coronary heart disease. But this death came two years *after* the entry was supposedly made, so the records were clearly manufactured later.

Plaintiff's counsel did not reveal that he knew of this discrepancy until he cross-examined the defendant at trial. Though the defendant did not admit he had created new records, this was obvious. The jury brought in a substantial verdict for the decedent's estate.

Scientific Methods

An expert document examiner can conduct visual examinations and measurements and more technical tests, including chemical analysis, ultraviolet and infrared examination, chromatography, and spectrophotometry, to analyze and sometimes date paper, inks, latent fingerprints, and erasures.[4] For example, many companies change the composition of inks used in pens or typewriter ribbons at the beginning of each year, permitting dating of entries.

A document examiner can produce dramatic and conclusive results. In a case handled by one of us, an expert used a portable infrared viewer to analyze the chemical composition of inks on a page of office notes. A suspicious exculpatory entry disappeared from view when a particular filter was used, indicating the entry was not from the same pen as the other entries on the page. Because it is technically possible to date ink samples using a sample from the paper the size of a pin prick, the originals were again requested so that ink-timing studies could be done to determine when the entry was added. This caused the defense counsel to confront the physician, who confessed to having added the entry after receiving the initial request for the patient's records. The case settled quickly.

Discovering an alteration will almost always increase the settlement value of a case. It is more difficult when documents are lost or destroyed, but recent case law makes even this the subject of new sanctions and new claims for relief.

Inferences and Presumptions of Negligence

A maxim of the law of evidence is *omnia praesumuntur contra spoliatorem*—all things are presumed against a despoiler.[5] In cases involving missing hospital records, courts have found that proof of the intentional spoliation or suppression of evidence favorable to an adversary allows the jury to infer guilt or negligence.

For example, in *May v. Moore*,[6] where an infant had died from improper treatment after birth, the chart "disappeared," but not before a hospital administrator had copied it, knowing the treating physician often "lost" records that chronicled poor outcome for his patients. The Alabama Supreme Court held that even testimony about this physician's earlier "lost" records was admissible and sufficient to create an inference of negligent treatment. Also, the court upheld imposing sanctions for the physician's failure to comply with discovery orders during the time the records were "lost."

The physician later "found" the records, but they differed markedly from the copy the hospital administrator had retained. The jury brought in a verdict for the plaintiff.

Sanctions and Punitive Damages

Court discovery rules may allow an award of expenses or of attorney's fees to plaintiff if defendant refuses to comply with valid discovery orders. Costs and fees incurred in discovering the alteration of the record may also be recovered.

Once plaintiff's counsel proves that records have been altered or destroyed, punitive damages can be sought in two ways. First, counsel can state a claim for fraud, conspiracy, breach of fiduciary duty, or the new tort of intentional spoliation. Second, plaintiff can allege that the underlying medical negligence was so reckless or wanton as to be apparent to defendant, who took pains to alter or destroy the evidence. Some states recognize the doctrine of "aggravated conduct," under which punitive damages can be obtained by reason of conduct so extraordinary that the suit is no longer merely for negligence.

Though no cases could be found in which plaintiff obtained an award of punitive damages based on a claim arising from the alteration alone, it is certain that such claims have been pleaded, though the cases settled.

As technology advances, the ability to prove that a record has been altered increases. Concurrently, the kinds of claims that can be made against defendants are finding support in the case law. As technology and law evolve, a higher duty will be imposed on doctors to retain their patient's records intact and greater sanctions will be imposed for their alteration or destruction of records.

Among the remedies plaintiffs' lawyers can seek are (1) sanctions for failure to comply with discovery orders; (2) jury instructions creating a presumption against the despoiler; (3) compensatory and punitive damages for the spoliation; and (4) elevation of the negligence claim to one for wanton, reckless, or aggravated conduct, so that punitive damages can be awarded.

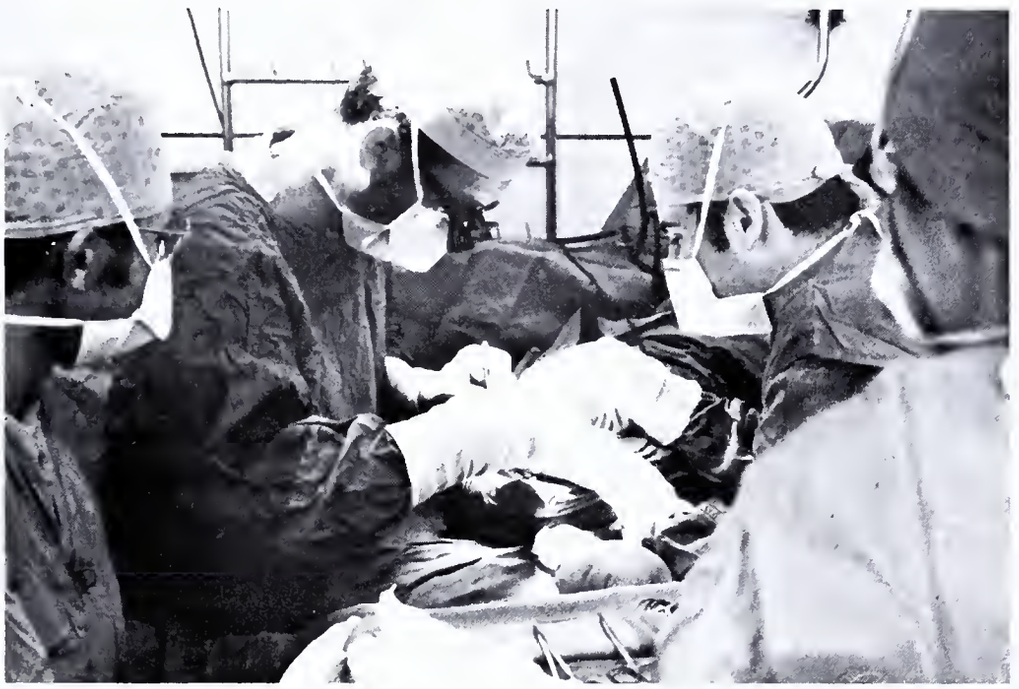
Notes

1. Harris & Mills, *Medical Records and the Questioned Document Examiner*, 8 J. FORENSIC SCI. 460 (1963); *Questioned Document Examination*, 3 FORENSIC SCIENCES 39.03 (C. Wecht ed. 1983).
2. Harris & Mills, *supra* note 1.
3. Wilson v. Bierenbaum, No. L-19868-85 (N.J. Super. Ct. Jan. 30, 1987) (analyzed in NAT'L JURY VERDICT REV. & ANALYSIS, Mar. 1987).
4. *See* FORENSIC SCIENCES, *supra* note 1, at 39.03(d); Brunelle, *Comparison of Typewriter Ribbons Inks in Thin-layer Chromatography*, 22 J. FORENSIC SCI. 807 (1977).
5. BLACK'S LAW DICTIONARY 1238 (5th ed. 1979); Appleton Elec. Co. v. Advance-United Expressways, 494 F. 2d 126, 139 n.24 (7th Cir. 1974).
6. 424 So. 2d 596, 603 (Ala. 1982).

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Exchange Insights is not intended to provide legal advice, and no attempt is made to define conduct which would have been appropriate in particular cases to meet acceptable standards of care.

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Marshfield Clinic

BOT Abstracts

(continued from page 70)

contingent upon approval by legal counsel.

- Approved the following change in the dues statement: That the statement indicate a total amount including a contribution to IMPAC. The disclaimer on the statement would continue to indicate that contributions to IMPAC are totally voluntary.

NOMINATIONS AND APPOINTMENTS

Various nominations and appointments were approved by the Board as follows:

- Approved appointment of ISMS members to one-year terms on the Society's councils and committees for 1988-89.
- Appointed council chairmen were: Drs. Alfred J. Kiessel, Decatur, Council on Economics; Boyd E. McCracken, Greenville, Council on Education and Manpower; Terry Mason, Chicago, Governmental Affairs Council; Geoffrey Bland, Springfield, Medical Legal Council; James L. McGee, Decatur, Council on Medical Services; Thomas Minogue, Urbana, Council on Mental Health and Addiction; and Jane Jackman, Springfield, Council on Public Relations and Membership Services.
- Appointed chairmen of committees reporting directly to the Board were: Drs. Dean Bordeaux, Peoria, Committee on CME Accreditation; Vincent A. Costanzo, Jr., Chicago, Committee on Drugs and Therapeutics; Henrietta Herbolsheimer, Chicago, Committee on Health Planning; L. Michael Newman, Evanston, Physician Assistance Committee; and Boone Brackett, Oak Park, Peer Review Appeals Committee.
- Approved a roster of physician nominees for submission to the AMA for seven Residency Review Committees.
- Approved nomination of Jerome H. Stone for AMA Layman of the Year Award.

PROGRAMS

The Board ratified selection of the following INTRAV trips for 1989: South Pacific Islands Air/Sea Cruise, Wings over Kenya Air Safari, Carnival in Rio South American Air/Sea Cruise, China/Yangtze River Adventure and Sea Goddess Adventure.

INFORMATIONAL REPORTS

The Chicago Medical Society (CMS) indicated plans to reconsider CMS Resolution 88-2B, which concerns the Medical Practice Act, which had been submitted to ISMS.

Informational reports were presented by the Committee on CME Accreditation, ISMIS, Resident Physicians Section, Medical Student Section, Hospital Medical Staff Section Governing Council, Trustees, Speaker, Vice Speaker, AMA Delegation Chairman and Executive Vice President.

NEXT MEETING

The next Board of Trustees meeting will be held on September 10, 1988, at ISMS Headquarters. ◀

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

CHICAGO SUBURBAN:
MacNeal Hospital, a major teaching affiliate of Rush-Presbyterian-St. Luke's Medical Center, seeks family practitioners and obstetricians. Opportunities include private practice, solo, partnership, practices for sale, salaried positions. Individualized comprehensive financial package. BE/BC family practice; OB/BC family practice; OB/GYN. Forward CV: Physician Affairs, 3249 S. Oak Park Avenue, Berwyn, IL 60402. (10)

FLORA:
Small, progressive hospital in Southern Illinois seeks general surgeon. Beautiful small town, scenic area, yet only an hour's drive from major metropolitan areas. Financial assistance and office space available. As the only general surgeon in the community, you would be assured of a lucrative practice, plus a real challenge. Contact: John E. Monnahan, Administrator, Clay County Hospital, 700 North Mill, Flora, IL 62839; (618) 662-2131, ext. 228. (7)

FLORA:
Small, progressive hospital in southern Illinois seeks family practitioner. Beautiful small town, scenic area, yet only an hour's drive from major metropolitan areas. Financial assistance and office space available. Contact: John E. Monnahan, Administrator, Clay County Hospital, 700 North Mill, Flora, IL 62839; (618) 662-2131 ext. 228. (9)

HAZEL CREST:
South Suburban Hospital has immediate opportunity for board certified, or board eligible family practitioner/internist. Physician will assume control of well established practice of retiring physician. Relocation allowance; loan guarantees: marketing support available. Will consider candidates currently finishing residency. For this and other practice opportunities, direct C.V. to Joe Dwyer, Vice-President Marketing, South Suburban Hospital, 17800 S. Kedzie, Hazel Crest, IL 60429. (9)

MACOMB:
Seeking physician for full-time position in emergency room of community hospital with 11,000/yr ER visits. This modern 155-bed level II trauma and poison control center has excellent specialty backup and maintains a 24hr.-ER and paramedic ambulance system. Services area covering 40,000 patients. Located in Macomb, just 80 miles northwest of Springfield. This university town offers excellent cultural, educational, and recreational opportunities. A comfortable, "safe" family community. Attractive compensation based on 48-hour week plus malpractice and benefit package provided. Send CV to George Roodhouse, D.O., McDonough District Hospital, 525 E. Grant, Macomb, IL 61455. (7)

QUAD-CITIES
Emergency medicine/ambulatory care opportunity, aggressive private group covers brand new (construction completed March 1988) level II trauma center and ambulatory care center. Compensation highest in area. Immediate opening. Contact Premier Emergency Group, P.C. 3024 Chateau Knoll, Bettendorf, IA 52577. Phone: (319) 332-5927. (9)

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POSITIONS AND PRACTICE

WELL ESTABLISHED PRACTICE general surgery and general practice looking for associate who will buy within six months to one year or right now. 40 miles from Chicago. Twenty years established practice, excellent income. Substantial income from hospital on trauma call. Looking for a partner or associates. Reply to Box 2061, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FAMILY PHYSICIAN—Well equipped 48-bed rural JCAH accredited hospital is looking for a family physician to round out their medical staff. Modern furnished five room clinic located on hospital grounds provided. Lucrative financial package including guarantee for initial period. Unbelievable income potential. The hospital is located in southeastern Illinois in the midst of the Shawnee National Forest. Excellent area for fishing, hunting, boating, etc. Contact Roby Williams, Administrator, Hardin County General Hospital, P. O. Box 2467, Rosiclare, IL 62982. Telephone—(618) 285-6634.

PEDIATRICIAN WANTED to establish practice in NW Illinois city of 17,000, service area 60,000+. Space available in fully-equipped office 1 block from hospital with new peds. unit and level II nursery. 100% of collections, no buy-in. Office rent negotiable. 1-2 hours from Chicago, other large cities. For more information or to schedule visit, write S. Baumwell, M.D., 202 W. Miller Road, Sterling, IL 61081 or call collect (815) 626-9660.

SOUTHWESTERN CHICAGO SUBURBAN AREA—Seeking board-certified or board-eligible family practitioners, internists, pediatricians and obstetricians/gynecologists for positions in a rapidly developing hospital service area of 350,000 population 35 miles from Chicago's Loop. Positions offer highly-competitive, one to two year guaranteed annual salaries plus benefits including malpractice, life, long-term disability and health insurance, moving and interview expenses, and paid vacation and sick leave time. For further information, submit a current curriculum vitae or call (collect): Robert W. Matthews, Ph.D., Director of Special Projects, 1200 Maple Road, Joliet, IL 60432, (815) 740-7093, (815) 740-7094 after 6 pm/weekends.

ANESTHESIOLOGIST. Seeking 3 BC/BE well-trained anesthesiologists to join 8 physicians and 12 CRNAs in a busy group practice which includes cardiothoracic, neuro, neonatal, and OB at a 650 bed hospital with an academic affiliation. Sub-specialities considered, especially cardiac, pediatric, and obstetrics. Excellent salary and benefits. Send CV to Quentin A. Pletsch, M.D., St. John's Hospital, 800 East Carpenter, Springfield, IL 62769.

TWENTY-NINE PHYSICIAN multispecialty clinic located in desirable east central Wisconsin location is seeking board certified or board qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D. F. Sweet, M.D., Fond du Lac Clinic, S.C., 80 Sheboygan Street, Fond du Lac, Wisconsin 54935.

CARDIOLOGIST—ST. LOUIS, Missouri area. Excellent opportunity for a board eligible/board certified cardiologist to join an established board certified cardiologist in private practice. Position offers above average compensation plus fringe benefits including malpractice, life, disability and health insurance, moving expense reimbursement and paid vacation. Partnership after two years' satisfactory employment. For further information, send CV to Box 2109 c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

OB/GYN, FAMILY PRACTICE, ENT, and general internist, needed for two-hospital, historic river town of 20,000. Drawing area of approximately 60,000 with new 19,000 acre recreational lake. Unlimited potential. Contact Carol Murphy, Physician Recruitment, 623 Broadway, Hannibal, MO 63401, or call 314-221-3107.

FAMILY PHYSICIAN/INTERNIST: Estherville medical center seeking associates to join two boarded family practitioners. Estherville, Iowa, a rural community with several small industries, located within 15 miles of the "Iowa Great Lakes" in northwest Iowa. Excellent up-to-date community hospital. School system ranks among the finest in the state. Guarantee plus additional remuneration based on productivity. Contact Raymond Wolf, 15975 West National Avenue, New Berlin, WI 53151 or call (414) 784-2777.

WAUKON, IOWA—Family physician to join a well-established three-physician family practice clinic that has affiliated with Franciscan Health System of La Crosse, Wisconsin. Excellent financial benefits. Education and recreation is truly outstanding. Contact Raymond F. Wolf, 15975 W. National Avenue, New Berlin, Wisconsin 53151 or call (414) 784-2777.

URGENT—FP/GP PHYSICIANS needed for practice opportunities within Arizona and throughout the United States. Excellent group and solo opportunities available. For additional information, please call (602) 990-8080; or send CV in confidence to: Mitchell & Associates, Inc., P.O. Box 1804, Scottsdale, Arizona 85252.

PHYSICIANS TO TAKE IN-HOUSE CALL. Ideal position for residents and moonlighting physicians. Second year residents may be suitable. Call Donna, (815) 395-5187 or write ETC, Ltd., P.O. Box 8034, Rockford, Illinois 61125.

ILLINOIS LICENSE—M.D. OR D.O. wanted to fill need for innovative "hands-on" physical medicine clinic. Growth potential is excellent. Send inquiries/vita to P.O. Box 3633, Peoria, IL 61614.

ARIZONA-BASED physician recruiting firm has opportunities coast-to-coast. "Quality Physicians for Quality Clients since 1972." Call (602) 990-8080; or send C.V. to: Mitchell & Associates, Inc., P.O. Box 1804, Scottsdale, AZ 85252.

ANESTHESIOLOGIST WANTED. B.C. preferred, will consider B.E. Remuneration based on fixed formula for all department members. Chicago north suburban setting. Must be able to perform all types of anesthesia and supervise CRNA's. Please reply to Box 2113, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

PHYSICIAN TRAINED in family practice and obstetrics to join a very busy established practice in Marseilles, IL. Call day or night, (815) 795-2122 or (815) 795-4600. Ask for Herman Kelly Sutton, M.D.

SAN DIEGO, CA—Hospital affiliated primary care group seeking additional associates. BC/BE in family medicine and internal medicine. New state-of-the-art, outpatient primary care centers. Excellent compensation package with benefits and incentive. Send C.V. to Medical Director, Mercy CarePoint Medical Group, 1011 Camino del Rio So., #450(S), San Diego, CA 92108.

IMMEDIATE OPENING. One internist to head the medical services at a 250-bed acute treatment psychiatric hospital, JCAH approved, Medicare certified, affiliated with the university. Forty-hour work week. No night or weekend on call. Situated in picturesque northeast Iowa near large cities with cultural advantages. Ideal for family living. Golf club, hunting and fishing area, good schools, etc. Salary to $81,012. State law protects employees against malpractice. State pension plan. Unique deferred annuity plan. Generous sick leave and vacation. Write or call collect: B. J. Dave, M.D., Superintendent, Mental Health Institute, Independence, IA 50644. Phone (319) 334-2583. An equal opportunity/affirmative action employer.

ANESTHESIOLOGY, DERMATOLOGY, family medicine, general surgery, internal medicine, orthopedics, otolaryngology, ob/gyn, pediatrics, psychiatry. A.L.R.M.G., is a 37 M.D. non-HMO clinic in beautiful Albert Lea, MN. These positions are created by retirements and development of new departments. The hospital and clinic are modern, progressive, established and the primary health care providers in our service area. Excellent educational and cultural opportunities. Competitive income, excellent benefits, early shareholder status with first year salary guarantee with incentive options. Send CV to: Administrator, A.L.R.M.G., 1602 Fountain St., Albert Lea, MN 56007-1642, or call (507) 373-8251 for further information.

IMMEDIATE OPENING, BC/BE internist to join ABIM internist in dynamic expanding practice, competitive salary guaranteed with incentive formula, full partnership at end of one calendar year. Midwestern city with two large well equipped hospitals. Send CV and inquiries to Box 2117, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

INTERNAL MEDICINE—Decatur, Illinois—95,000 population near Springfield, private practice for 1 or 2 general internists. New medical office complex adjacent to 316-bed hospital. Call sharing available, attractive financial incentives. Phil Kelbe, Fox Hill Associates, 250 Regency Court, Milwaukee, Wisconsin 53186.

TIRED OF THE HECTIC metropolitan pace? Energetic int. or fam. pract. wanted for rural community. Must be willing to make long term commitment. Modern, progressive, well equipped & staffed hospital. Excellent medical staff relations. Attractive remuneration package. Serious candidates only. No agencies. Submit C.V. to: Marvin Schmidt, M.D. or Norman Reynolds, Adm. Mason District Hospital, P.O. Box 529, Havana, IL 62644; tel. (309) 543-4431.

MEDICAL DIRECTOR WANTED general medicine, family practice, internal medicine for a town of 25,000 and above. Ambulatory clinic setting. Salary $60,000 plus. Send resume to Anil Gupta, M.D., 3307 Broadway, Mt. Vernon, Illinois 62864.

MINNESOTA, IOWA AND WISCONSIN group practice positions are available for BE/BC physicians in the following specialties: family practice, adult/child psychiatry, internal medicine, occupational medicine, pediatrics, and obstetrics/gynecology. Competitive salary with benefits. Send letter of inquiry and curriculum vitae to Scott M. Lindblom, Fairview Clinic Services, 2312 South 6th Street, Minneapolis, Minnesota, 55454, or call (612) 371-6235, or toll free, 1-800-328-4661, ext. 6235. An equal opportunity employer.

GENERAL SURGEON BC/BE with training or experience in vascular surgery to join our three person general surgery group in west Tennessee in 1989. Competitive first year salary with fringe benefits and early partnership for right person. Practice in a community of 50,000 serving a population of 150,000 plus. Send CV to: Jackson Surgical Associates, 686 W. Forest, Jackson, TN 38301.

WANTED—BOARD ELIGIBLE/BOARD certified emergency medicine physician to join an emergency department staff which is part of a 200 physician multi-specialty clinic in Champaign-Urbana, Illinois; 35,000 annual visits. Liberal fringe benefits and salary lead to equal ownership. Send CV with inquiries to J. Yambert, M.D., Division of Emergeney Medicine, Carle Foundation Hospital, 611 West Park, Urbana, IL 61801; (217) 337-3313.

SITUATIONS WANTED

BOARD-CERTIFIED OB/GYN seeking part-time positions. Please reply to Box 2047, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CERTIFIED FAMILY-PRACTITIONER seeking part-time position. Reply to Box #2048, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED INTERNIST—Buy practice or other. Reply to Box 2115, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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BOLINGBROOK PROFESSIONAL BUILDING—A well decorated and furnished medical office available for sharing rent and expenses. Very reasonable terms. Please call (312) 852-1948 or (312) 759-5000 for additional information.

MEDICAL EQUIPMENT for sale/lease. New and used exam room furniture, EKG's, hyfracators, scales, diagnostic equipment, stretchers, more. Trade-ins accepted. Delivery available. 800-553-8367.

WELL-ESTABLISHED, FULLY-EQUIPPED internal medicine practice (of 10 years) in a 3 year old, self-owned medical offiee suite attached to an excellent hospital (450 beds, all specialties, cardiac surgery) 40 min. from downtown Chicago. Practice grossing over $270,000; for sale or contract. Send resume to Box 2111, c/o *Illinois Medical Journal*, Twenty North Michigan Ave., Suite 700, Chicago IL 60602.

FOR SALE—Bariatric practice, Lake County, Illinois. Established seven years, gross $100m. Twenty to twenty-five hours weekly, afternoons. Low overhead. Will stay, train, or consider partnership. Reply to Box 2110, c/o *Illinois Medical Journal*, Twenty N. Michigan Ave., Suite 700, Chicago, IL 60602.

EENT PRACTICE FOR SALE. Established 41 years in so. suburbs. Can use either speeialty alone or both. Located in shopping area. Best offer. Telephone (312) 754-1156.

PRACTICE FOR SALE: 63 year old, 2nd generation general practice; 1½ hour drive so. of Chicago; on ground floor in two story building, for sale or rent. Office 12 rooms for 2-3 physicians. Excellent accredited hospital 4 blocks away with all specialties. Reply to Box 2112, c/o *Illinois Medical Journal*, Twenty N. Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR QUICK SALE—Well established general practice in Chicago's southside with gross income of well over $140,000.00 per annum. Building with 4 exam rooms, x-ray, dentist, laboratory, pharmacy and large reception area. Rental income of $18,000.00 per annum. Owner will refinance balance at 8% for 2 years. Serious interested party call Arlene at (312) 679-4161 from 9 am-5 pm; 272-9442 after 7:00 pm.

FOR SALE: Completely furnished office for general practitioner, town of 3500—county seat, excellent location. Present doctor is retiring after 60 years of practice. Wilson L. DuComb, M.D., 891 Mulliken St., Carlyle, Il. (618) 594-3435.

FREE RENT TO START—Medical suite. Beautiful office-prestigious modern bldg. Excellent busy location. Three exam rooms, lab, private office, two washrooms. Parking. Near three hospitals, (312) 662-1664.

PLANNING YEAR-END RETIREMENT. Prime internal medicine practice available for dedicated physician. Joliet area. Price—one-half gross income. Reply to Box 2114, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

INTERNAL MEDICINE— Oak Park. Great growth opportunity in an already well established practice—$85,000. Medidentic Practice Sales (312) 696-0220.

NORTH SUBURBAN OB-GYN. Solid practice in excellent location. Grossing mid-$300,000s. Owners retiring. Asking $175,000. Medidentic Practice Sales (312) 696-0220.

NORTHWEST SUBURBAN general medicine. New, well equipped and well furnished office with a solid nucleus of patients. Great starter or satellite location—$35,000. Medidentic Practice Sales (312) 696-0220.

NORTHWEST SUBURBS—internal medicine and non-invasive cardiology. Comfortable spacious facility adjacent to prestigious hospital. Asking $90,000. Medidentic Practice Sales (312) 696-0220.

OAK LAWN—FAMILY PRACTICE. Across the street from prestigions area hospital. Board certified or board eligible. Owner retiring. Asking $65,000. Medidentic Practice Sales (312) 696-0220.

WEST SUBURBAN medical practice available. Retiring doctor grossing $425,000. Established 27 years. Reasonably priced. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093; (312) 441-6111.

FOR RENT—Build your practice in rapidly expanding Bolingbrook. New ultra modern medical/dental center. Well equipped, comfortable medical suites with many amenities. Particularly well suited for internal medicine specialists and orthopedic, ophthalmology, pediatrics, cardiology, etc., physicians and surgeons. Large illuminated and landscaped parking area. For more information, call Stetson Realty Capital at (312) 620-6550.

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TIRED OF PAYING physician search firms? For information write or call Physician Consultants Inc., 4107 Chesapeak Dr., Su. 3D, Aurora, IL 60504; (312) 820-8282.

BRING YOUR PROFILE/MAAC REPORT. This seminar will address concurrent care issues. Attendees will learn how to deal effectively with Medicare claims and increase part B reimbursement. The agenda will include medically unnecessary services, non-covered services, freedom of information act, profile analysis-maximizing customary/prevailing profiles and MAAC compliance. New reimbursement opportunities and case studies will be discussed. Group and individual Q&A will follow presentation. Who should attend: par and non-par physicians and insurance claims managers Location: Hyatt-Lisle; Date: July 26, 1988; Time: 7:00 pm-9:30pm; Fee: $195.00; Registration: (312) 310-3385; Partners in Physician Education. Presenter: Norman Brooks of Professional Practice Development.

HEALTH CARE PERSONNEL CONSULTING, Inc., a division of The Health Care Group, specializes in valuation and sales. We have practices currently available in the following specialty areas: dental, dermatology, family practice, internal medicine and ophthalmology. For more information regarding selling or buying a medical practice, contact our brokerage division at Health Care Personnel Consulting, Inc., Meetinghouse Business Center, 140 West Germantown Pike, Suite 200, Plymouth Meeting, PA 19462; or call (215) 828-0919.

General Internist

Marshfield Clinic, a 260 physician multispecialty group practice, is seeking BE/BC General Internal Medicine specialists to join its expanding department in Marshfield, Wisconsin. The department is currently staffed by 23 General Internists with immediate plans to add seven or more additional members. The current call schedule is generally one night per month and one out of five weekends. An Internal Medicine Residency Program, University of Wisconsin Medical School affiliation, Medical Research Foundation, and ongoing new developments, i.e. Geriatrics Evaluation Center and Walk-in Medicine contribute to a very stimulating environment. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. We offer a current starting salary up to $85,000 with salary in two years up to $110,000. Fringe benefit package outstanding. Send CV and references to:

David L. Draves
Department of Administration

1000 North Oak Avenue
Marshfield, WI 54449
or call collect (715) 387-5376

Marshfield Clinic

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J-6138 January 19

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REPORT FOR *Illinois Physicians*

"UNBUNDLING" OF CPT CODES

There are an increasing number of claims for surgical procedures received by Blue Cross Blue Shield that are coded with incorrect CPT codes. These claims primarily involve the inappropriate "unbundling" of surgical services by the coding and pricing of each component of a complex surgical procedure, thus inflating the total price of the procedure. Blue Cross Blue Shield is closely monitoring this type of coding and billing practice and will be contacting those physician offices involved. Some examples of inappropriate coding practices with the correct coding procedures are:

INCORRECT				CORRECT			
Date	**Code**	**Description**	**Fee**	**Date**	**Code**	**Description**	**Fee**
4/1/88	47600	Cholecystectomy	$1200	4/1/88	47605	Cholecystectomy with cholangiography	$1500
4/1/88	47605	Cystic Duct Cholangiogram	$ 600				
4/1/88	29870	Arthroscopy, knee	$1000	4/1/88	29881	Anthroscopy, knee with meniscectomy	$1500
4/1/88	29881	Arthroscopy, knee with meniscectomy	$1000				
4/1/88	31020	Maxillary Sinusotomy, left	$ 750	4/1/88	31020-50*	Maxillary Sinosotomy, bilateral	$1125
4/1/88	31020	Maxillary Sinosotomy, right	$ 750	*Use of modifier 50 to indicate a bilateral procedure			
4/1/88	58980	Laporoscopy	$ 850	4/1/88	58985	Laporoscopy with lysis of adhesions	$1000
4/1/88	58985	Laporoscopy with lysis of adhesions	$1000	4/1/88	58987-51*	Laporoscopy with aspiration	$ 500
4/1/88	58987	Laporoscopy with aspiration	$1000	*Use of modifier 51 to indicate multiple procedures at the same operative session			

If you need assistance in determining the proper CPT coding of multiple surgical services performed at the same operative session, please call Brenda Hammond at (312) 938-7882.

NOTIFICATION TO PROVIDERS ON CLAIM FILING DEDUCTIONS

Beginning in May, 1988, a claim filing limitation was implemented for all National Accounts throughout the nation. In order to avoid payment delays for any of your patients affected by this filing limitation, it is important that all claims be filed within six months of the date the services were rendered.

This filing limitation applies not only to Central Certification groups but to all National Accounts regardless of where the membership records are retained.

MEDICARE NOTES

EXTRACORPOREAL PHOTOPHERESIS (Effective for services performed on or after April 8, 1988)

Extracorporeal photopheresis is a treatment for cutaneous T-cell lymphoma (CTCL), a condition that is generally resistant to chemotherapy and radiotherapy. The treatment begins with the oral administration of the drug methoxalen. The patient's blood is then passed through a device that permits exposure of the blood, while it is outside the body (extracorporeal), to ultraviolet A light. The blood is then returned to the patient.

Extracorporeal photopheresis is covered by Medicare only when used in the palliative treatment of the skin manifestations of CTCL that has not responded to other therapy.

The following new code has been established for this procedure:

X3654 Extracorporeal photopheresis

X-RAY AND EKG INTERPRETATIONS BY ATTENDING PHYSICIAN OR EMERGENCY ROOM PHYSICIAN

There are situations where a radiologist or cardiologist interprets an x-ray or EKG that has already been interpreted by an attending physician or emergency room physician.

While the services of both physicians are covered, **separate** reimbursement cannot be made for the interpretation by the attending/emergency room physician. The attending/emergency room physician's charge for the **overall work-up or treatment** of a patient **includes** the interpretation of an x-ray or EKG ordered by that physician.

Hospital visits/emergency room visits which **include** an x-ray or EKG interpretation should be billed at a higher level of service than a hospital visit/emergency room visit which does not include that additional service.

WEEKLY MEGAVOLTAGE TREATMENT MANAGEMENT— ADDITIONAL INFORMATION/CLARIFICATION

The following information was included in the April 1988 Major Mailing and the May 1988 Blue Sheet:

Global fees have been established for billing weekly megavoltage treatment management codes in a non-hospital setting. Weekly treatment management codes will be effective for treatments rendered in a free-standing facility May 1, 1988 and thereafter. **Daily** treatment management codes **in a free-standing facility** will **not** be recognized by Medicare after this date.

The global weekly management fee includes treatment management, medical radiation physics, dosimetry, treatment devices, and port films.

Procedure codes for weekly megavoltage treatment management provided in a free-standing facility are:

77420 — simple
77425 — intermediate
77430 — complex

In addition to the weekly management code, providers will be reimbursed for the following radiation therapy-related services if rendered, **per treatment phase**:

- Preliminary Consultation when provided by the therapeutic radiologists.
- One therapeutic radiology plan.
- **3** therapeutic radiology simulation-aided field settings.
 (This was incorrectly published as **one** in the May Blue Sheet.
 The April mailing correctly indicated **3**.)

(This report is a service to the physicians of Illinois)

IMJ

Illinois Medical Journal
Illinois State Medical Society

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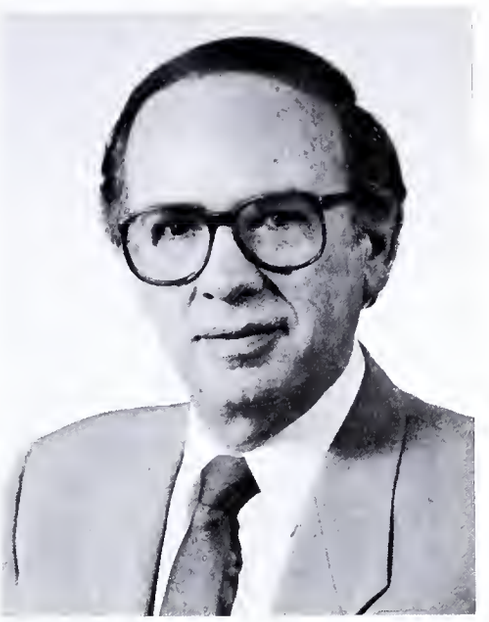
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A Right and A Duty



It is our duty as citizens to take part when health matters are at the center of public policy debate. The issues before the electorate are no longer simple, and the choices are increasingly complex. We are obliged to participate in choices which shape public health policy and affect our patients.

This is never clearer than in an election year. I won't waste your time with the arguments for registering to vote and exercising your rights at the ballot box. *There is simply no excuse for failing to vote.* It's absolutely the very least that you can do.

And in times like these, it's not enough. We, as physicians, must take a leadership role. We must examine the ramifications of this year's elections. What are the issues affecting medicine and our patients? Which candidates are best equipped to make sound choices when they represent us? Whose opinions are most reasoned and balanced?

In the last session alone, the Illinois General Assembly debated over 120 bills affecting either the regulation of medicine or the public health. Our state legislature will decide whether mandatory Medicare assignment becomes law in Illinois. They will approve or deny the budget allocation for public aid and mental health. They will assign priorities to medical malpractice tort reform—or its reversal. It's clearly in our best interest to participate in politics at all levels.

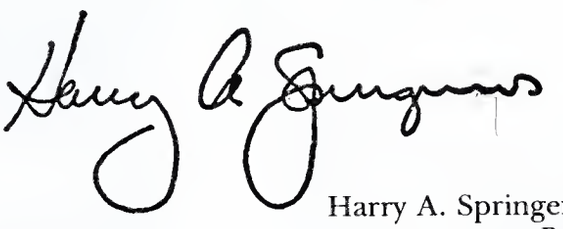
Locally, physicians can join campaign committees, make speeches on behalf of candidates, host fundraisers, and walk precincts. Community work benefits the community—and it keeps us in touch with our patients.

Participating in the Illinois State Medical Society Political Action Committee (IMPAC) is the most efficient way to influence races outside our home districts. Fellow physicians on the IMPAC Board evaluate candidates across the state and allocate contributions. Financial support for a candidate or a political action committee (PAC) is infinitely practical. It's a free speech right guaranteed by the Constitution. And funding enables a candidate to bring his or her message to more people, more often and more effectively.

Doctors' contributions to the Illinois Medical Political Action Committee (IMPAC) are sadly lagging. I find it extremely ironic. We have a simple, convenient means to affect legislative action. But less than half of ISMS members join IMPAC, and those who do most often give only $50.

This shortsightedness appears to be peculiar to medicine: the average contribution to PACs by other special interest people and professionals runs about $100 a member—and well over half the members participate.

We have to do something about this disparity. Contributing to IMPAC is a right and a duty. We need solid political representation to maintain a healthy environment for medicine in Illinois. If you haven't joined IMPAC, please do so today. And if your colleagues don't know the arguments, please get them thinking. ◀



Harry A. Springer, M.D.,
President

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, & 110.5 (Federal Regulations require this notice.) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC. Contributions to AMPAC and IMPAC are not deductible as charitable contributions for federal income tax purposes.

THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was prepared by Ross Benjoya, M.D., department of radiology, Loyola Universit Medical Center, Maywood.

This 5-year-old child has a history of recurrent laryngeal and tracheal lesions. Multiple endoscopic surgical procedures have been performed in the past.

Figure 1
Chest radiograph shows multiple lung nodules and a tracheostomy tube. Some nodules are cavitated.

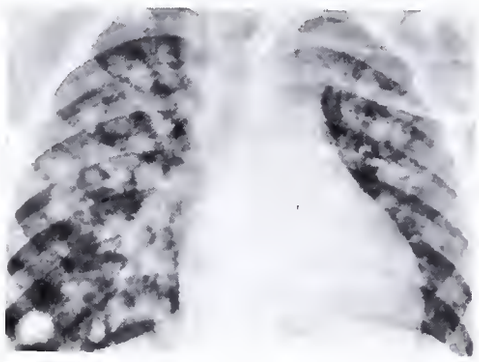


Figure 2
Chest computed tomography.

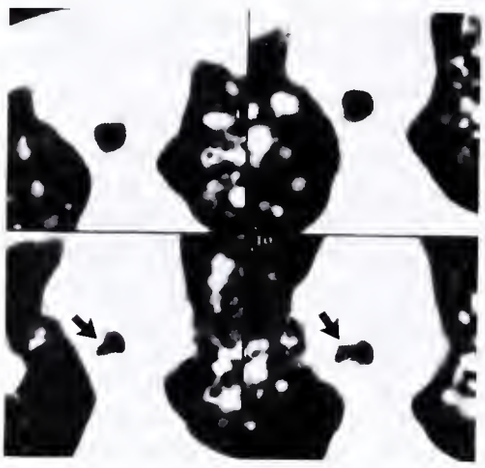


Figure 2A
There is irregular narrowing of the trachea and right main bronchus. (arrows)

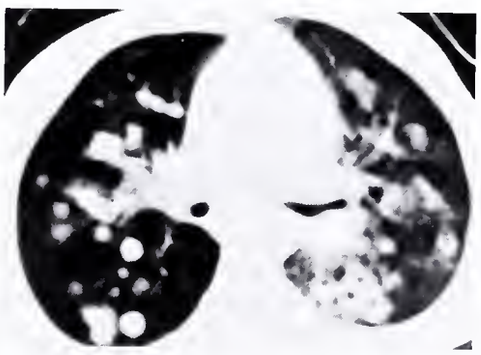


Figure 2B
There are multiple solid and cavitary lung nodules.

Your diagnosis?

1. Juvenile laryngeal papillomatosis
2. Wegener's granulomatosis
3. Amyloidosis
4. Relapsing polychondritis

(Continued on page 158)



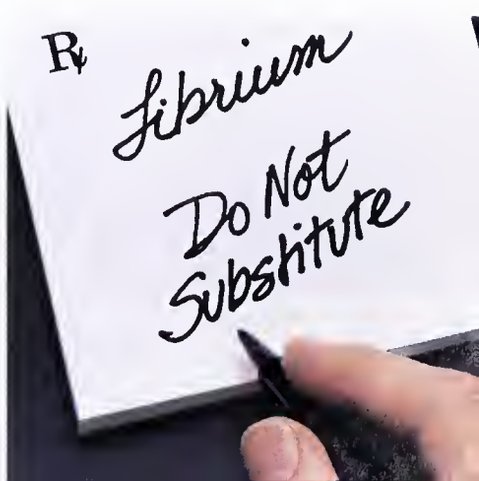
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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

Due to the reorganization of the Department of Professional Regulation, (formerly the Department of Registration and Education), ISMS has not received Disciplinary Orders for four months. These are the first received since the hiatus. Inquiries about disciplinary actions taken during this period should be directed to the Department of Professional Regulation.

From the Department of Professional Regulation

Disciplinary Orders

- *Sunan Ajharn* (lic. # 036-051012)
 Effective May 12, 1988, Dr. Ajharn's medical license was suspended indefinitely.
- *Pedro Alupay* (lic. # 036-065272)
 Effective May 12, 1988, Dr. Alupay's medical license was suspended indefinitely.
- *Virgilio Barangan* (lic. # 036-044230)
 Effective March 25, 1988, Dr. Barangan's medical license was reprimanded and placed on probation for three years.
- *George Barnett* (lic. # 036-025898 & 003-036-025898)
 Effective March 10, 1988, Dr. Barnett's medical license was revoked, but the revocation was stayed to the extent that the license was placed on indefinite probation with his practice limited. In addition, his controlled substance license was revoked.
- *Robert James Berecz* (lic. # 036-041366)
 Effective May 12, 1988, Dr. Berecz' medical license was suspended indefinitely.
- *Richard A. Brady* (lic. # 036-055719 & 003-036-055719)
 Effective May 16, 1988, Dr. Brady's medical and controlled substance licenses were indefinitely suspended.
- *Paul Burgert* (lic. # 036-041155)
 Effective May 12, 1988, Dr. Burgert's medical license was suspended indefinitely.
- *William A. Calderwood* (lic. # 036-042991)
 Effective May 12, 1988, Dr. Calderwood's medical license was suspended indefinitely.
- *Robert S. Callaghan, Sr.* (lic. # 036-038997)
 Effective April 12, 1988, Dr. Callaghan's medical license was placed on probation for 2 years, with certain conditions.
- *Gordon Cherwitz* (lic. # 036-030353)
 Effective May 16, 1988, Dr. Cherwitz' medical license was indefinitely suspended.
- *Homero Jose Corteguera* (lic. # 036-035190)
 Effective May 12, 1988, Dr. Corteguera's medical license was suspended indefinitely.
- *Milton Davis Jr.,* (lic. # 036-026695)
 Effective May 12, 1988, Dr. Davis' medical license was suspended indefinitely.
- *Hans E. Dolz* (lic. # 036-037644 & 003-036-037644)
 Effective May 16, 1988, Dr. Dolz's medical license was placed on probation and his controlled substance license was suspended.
- *Joseph C. Finney* (lic. # 036-034067)
 Effective March 25, 1988, Dr. Finney's medical license was surrendered indefinitely.
- *Demetrois J. Giokaris* (lic. # 036-066354 & 003-036-066354-1)
 Effective April 15, 1988, Dr. Giokaris' medical and controlled substance licenses were suspended.
- *Sidney Gottesmann* (lic. # 036-035960)
 Effective June 20, 1988, Dr. Gottesmann's medical license was reprimanded and he was fined.

(Continued on page 156)

A CORNERSTONE OF SECURITY

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STABLE

In an unstable professional liability climate, a stable insurance carrier is a **must**. Nearly 10,000 physicians have found a cornerstone of security in the Illinois State Medical Inter-Insurance Exchange, the state's first and largest physician-owned professional liability insurer.

The Exchange is the only carrier in Illinois which has continually offered coverage to new applicants since 1976. Our record is one of commitment to policyholders. That has sometimes meant difficult decisions, such as converting to claims-made insurance, setting realistic premiums and adhering to tough underwriting standards. That commitment—and these decisions—allowed the Exchange to stand firm when others were abandoning Illinois physicians.

AGGRESSIVE

Policyholders depend on the Exchange for aggressive defense. Claim examiners direct and monitor the legal team to see that the physician's voice is heard and that the defense is diligent, efficient and speedy. The Exchange continually audits its defense firms to enforce strict performance standards.

But, there is no better defense than prevention. The Exchange's loss prevention program helps physicians learn not only how to prevent suits, but also what steps to take for the best results once a claim or suit is filed.

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The Exchange exists for the Illinois physicians it insures. Its priorities are diligent claim management, careful underwriting and fiscal responsibility. A commitment to long-term vision, tempered by flexibility, will ensure stability and help to keep rates down. That commitment is a cornerstone of security for Illinois physicians.

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OBITUARIES

****Allen, Samuel S.,** Robinson, died June 13, 1988, at the age of 80. Dr. Allen was a 1934 graduate of Baylor College of Medicine, Houston.

Beinke, Victor H., Springfield, died July 10, 1988, at the age of 69. Dr. Beinke was a 1943 graduate of the University of Cincinnati College of Medicine, Cincinnati.

****Bell, Anthony J.,** Rock Island, died July 12, 1988, at the age of 81. Dr. Bell was a 1931 graduate of Loyola University Stritch School of Medicine, Maywood.

***Batko, Bernard B.,** Chicago, died July 16, 1988, at the age of 80. Dr. Batko was a 1936 graduate of the University of Health Sciences/Chicago Medical School.

***De Nyse, Walter J.,** Park Ridge, died May 4, 1988, at the age of 73. Dr. De Nyse was a 1940 graduate of Loyola University Stritch School of Medicine, Maywood.

***Finkel, Asher J.,** Chicago, died May 8, 1988, at the age of 72. Dr. Finkel was a 1948 graduate of the University of Chicago Pritzker School of Medicine, Chicago.

***Habegger, James E.,** Aurora, died July 9, 1988, at the age of 68. Dr. Habegger was a 1945 graduate of Northwestern University Medical School, Chicago.

***Hall, James L., Jr.,** Chicago, died July 9, 1988, at the age of 70. Dr. Hall was a 1952 graduate of Howard University College of Medicine, Washington, D.C.

****Kirstuk, Walter J.,** Chicago, died March 18, 1988, at the age of 75. Dr. Kirstuk was a 1938 graduate of Loyola University Stritch School of Medicine, Maywood.

***Majarakis, James D.,** Chicago, died April 21, 1988, at the age of 72. Dr. Majarakis was a 1940 graduate of the University of Chicago Pritzker School of Medicine, Chicago.

****McClelland, Charles A.,** Paris, died July 15, 1988, at the age of 77. Dr. McClelland was a 1938 graduate of Case Western Reserve University School of Medicine, Cleveland, Ohio.

***Nickey, William M., Jr.,** Springfield, died July 15, 1988, at the age of 59. Dr. Nickey was a 1952 graduate of the University of Tennessee College of Medicine, Memphis.

***Pawlikowski, Joseph S.,** Chicago, died May 10, 1988, at the age of 74. Dr. Pawlikowski was a 1939 graduate of Loyola University Stritch School of Medicine, Maywood.

***Seno, Louis S.,** Hillside, died July 3, 1988, at the age of 75. Dr. Seno was a 1944 graduate of the University of Health Sciences/Chicago Medical School.

****Thompson, Charles E.,** Chicago, died April 27, 1988, at the age of 82. Dr. Thompson was a 1929 graduate of the University of Nebraska College of Medicine, Omaha.

***Wishnick, Seymour D.,** Oak Brook, died June 17, 1988 at the age of 72. Dr. Wishnick was a 1943 graduate of the University of Health Sciences/Chicago Medical School.

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Please see facing [following] page for brief summary of prescribing information.

Systemic absorption of topical corticosteroids has produced reversible HPA suppression manifestations of Cushing's syndrome, hyperglycemia and glucosuria in some patients. Pediatric patients may demonstrate a greater susceptibility.

Reference: 1. Adams RM, Maiback HI, Clendenning WE, et al: A five-year study of cosmetic reactions. *J Am Acad Dermatol* 1985;13(6):1062-1069.

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Mytrex® CREAM AND OINTMENT, USP
(nystatin-triamcinolone acetonide)

Brief Summary of Prescribing Information

For Dermatologic Use Only
Not for Ophthalmic Use

INDICATIONS AND USAGE: For the treatment of cutaneous candidiasis; it has been demonstrated that the nystatin-steroid combination provides greater benefit than the nystatin component alone during the first few days of treatment

CONTRAINDICATIONS: This preparation is contraindicated in those patients with a history of hypersensitivity to any of its components.

PRECAUTIONS: General: Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings (see DOSAGE AND ADMINISTRATION). Therefore, patients receiving a large dose of any potent topical steroid applied to a large surface area should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests, and for impairment of thermal homeostasis. If HPA axis suppression or elevation of the body temperature occurs, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis function and thermal homeostasis are generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids. Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity (see PRECAUTIONS, Pediatric Use). If irritation or hypersensitivity develops with the combination nystatin and triamcinolone acetonide, treatment should be discontinued and appropriate therapy instituted.

Information for the Patient: Patients using this medicine should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occluded (see DOSAGE AND ADMINISTRATION).
4. Patients should report any signs of local adverse reactions.
5. When using this medication in the inguinal area, patients should be advised to apply cream sparingly and to wear loose fitting clothing.
6. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.
7. Patients should be advised on preventive measures to avoid reinfection.

Laboratory Tests: If there is a lack of therapeutic response, appropriate microbiological studies (e.g., KOH smears and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens, before instituting another course of therapy. The following tests may be helpful in evaluating hypothalamic-pituitary-adrenal (HPA) axis suppression due to the corticosteroid: Urinary free cortisol test, ACTH stimulation test.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic or mutagenic potential or possible impairment of fertility in males or females.

Pregnancy Category C: There are no teratogenic studies with combined nystatin and triamcinolone acetonide. Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. Therefore, any topical corticosteroid preparation should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Topical preparations containing corticosteroids should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Nursing Mothers: It is not known whether any component of this preparation is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised during use of this preparation by a nursing woman.

Pediatric Use: In clinical studies of a limited number of pediatric patients ranging in age from 2 months through twelve years, Nystatin-Triamcinolone Acetonide Cream cleared or significantly ameliorated the disease state in most patients. *Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced hypothalamic-pituitary-adrenal (HPA) axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area to body weight ratio.* HPA axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches and bilateral papilledema. Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.

ADVERSE REACTIONS: A single case (approximately one percent of patients studied) of acneiform eruption occurred with the use of combined nystatin and triamcinolone acetonide in clinical studies.

Nystatin is virtually nontoxic and nonsensitizing and is well tolerated by all age groups, even during prolonged use. Rarely, irritation may occur.

The following local adverse reactions are reported infrequently with topical corticosteroids. These reactions are listed in an approximate decreasing order of occurrence: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae and miliaria.

DOSAGE AND ADMINISTRATION: Cream: Apply MYTREX® (Nystatin-Triamcinolone Acetonide) Cream, USP to the affected area twice daily in the morning and the evening by gently and thoroughly massaging the preparation into the skin. Ointment: A thin film of MYTREX® is usually applied to the affected area twice daily in the morning and evening. MYTREX® should be discontinued if symptoms persist after 25 days of therapy. (See PRECAUTIONS, Laboratory Tests). MYTREX® should not be used with occlusive dressings.

Caution: Federal law prohibits dispensing without prescription.

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DOCTOR'S NEWS

ISMS PHYSICIAN SUPPORT GROUP

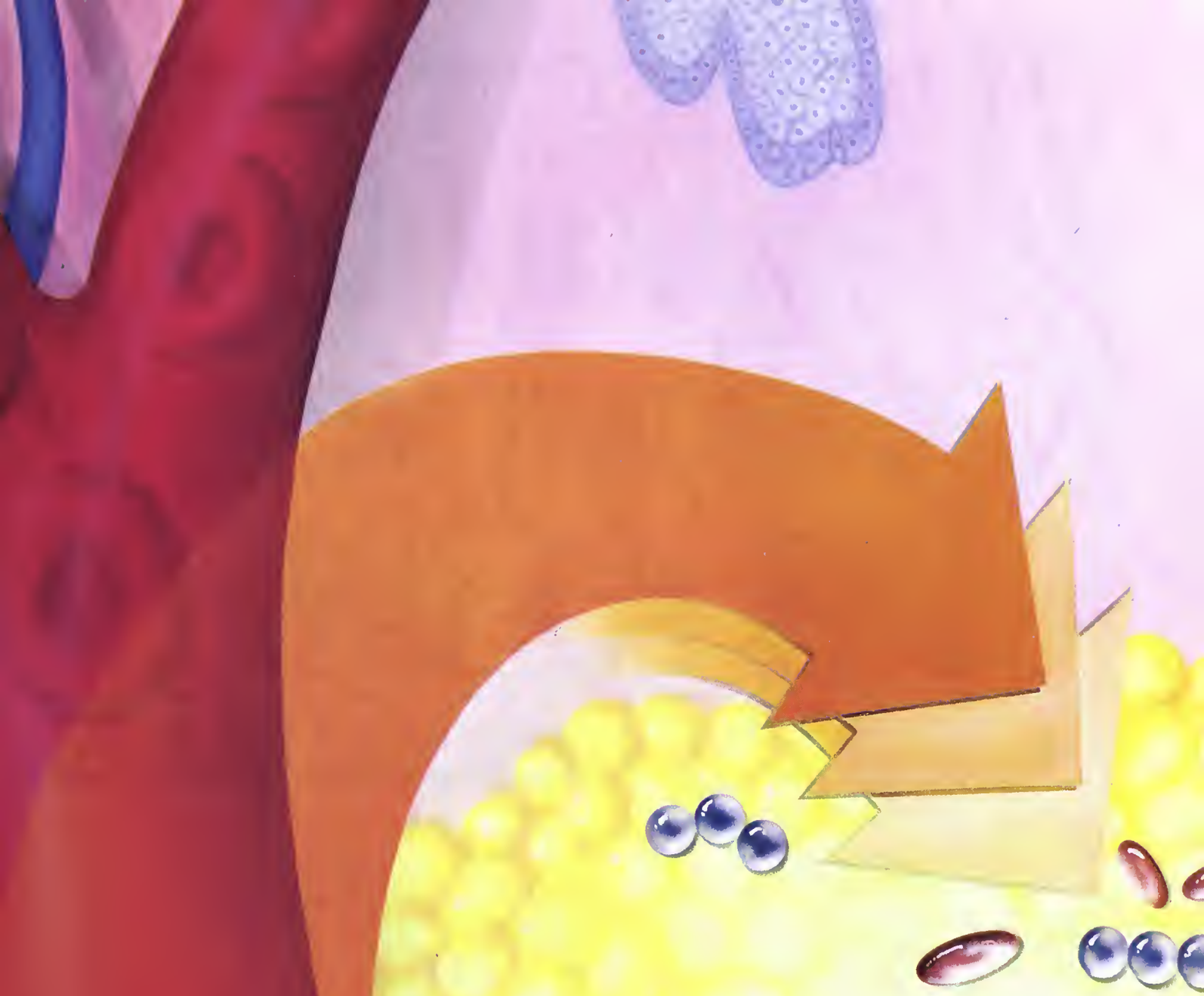
The ISMS Physician Support Group was established in 1984 to serve as a resource for doctors sued for malpractice. Recently, the group has explored other directions for involvement, such as educational seminars on the stress of malpractice litigation and the development of a brochure on the same subject. Due to this expanded focus new members are needed. If you are an ISMS member who has gone through the entire litigation experience and would like to become involved in the Physician Support Group, please contact ISMS at (312) 782-1654, extension 1147. Meetings are held quarterly, with the next meeting scheduled for October 5. All contacts with physicians are confidential.

PHYSICIANS IN THE NEWS

Mount Sinai Hospital North recently named **Dennis L. Citrin, M.D., Ph.D.,** Chicago, as its new medical director. Dr. Citrin is an internist and medical oncologist and also maintains a private practice in Chicago. . . . Appointed Cancer Liaison Physicians for the cancer programs at their community hospitals are: **Ralph A. Casciaro, M.D.,** Arlington Heights, for Northwest Community Hospital and **Joseph H. Gaziano, M.D.,** Sterling, for the Community General Hospital. Drs. Casciaro and Gaziano are among a national network of 2,300 volunteers participating in the Cancer Liaison Program, a part of the Commission on Cancer of the American College of Surgeons. Physicians in this program provide leadership and support to their hospitals' cancer programs and other Commission on Cancer activities. . . . **Herand Abcarian, M.D.,** of River Forest, has been elected president of the American Society of Colon and Rectal Surgeons. Dr. Abcarian is chairman of the Colon and Rectal Surgery Department of Cook County Hospital and a professor of surgery at the University of Illinois College of Medicine in Chicago.

RAILWAY SURGEONS HOLD ANNUAL MEETING

The American Association of Railway Surgeons will hold its 100th Annual Meeting at the Drake Hotel, Chicago, September 21-24. One of the oldest medical and surgical societies in the country, the AARS invites interested physicians to attend. Registration will take place from 8:00a.m. to 8:30a.m. Thursday, September 22 at the Drake. ◀



Penetration plus Duration*

Superior tissue penetration and duration of action

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(CEFADROXIL)

... the oral cephalosporin with once- or twice-a-day dosing

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For Brief Summary, please see following page.

DURICEF® (CEFADROXIL)
Penetration plus Duration
in Oral Cephalosporin Therapy

INDICATIONS: DURICEF (cefadroxil) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms: Urinary tract infections caused by *E. coli, P. mirabilis,* and *Klebsiella* species. Skin and skin structure infections caused by staphylococci and/or streptococci. Pharyngitis and tonsillitis caused by Group A beta-hemolytic streptococci. (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. DURICEF is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of DURICEF in the subsequent prevention of rheumatic fever are not available at present.)
Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.
CONTRAINDICATIONS: DURICEF is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.
WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF PENICILLINS AND CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE).
Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil). **Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.** Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated. When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should also be considered.
PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).
DURICEF (cefadroxil) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 ml/min/1.73M²). (See Dosage and Administration section of Prescribing Information.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.
Prolonged use of DURICEF may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.
Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug. DURICEF should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
Usage in Pregnancy: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to 11 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cefadroxil. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.
Nursing Mothers: Caution should be exercised when cefadroxil is administered to a nursing mother.
ADVERSE REACTIONS: *Gastrointestinal*—Symptoms of pseudomembranous colitis can appear during antibiotic treatment. Nausea and vomiting have been reported rarely.
Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug.
Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.
Before prescribing or administering, see package insert.

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

CHICAGO SUBURBAN:
MacNeal Hospital, a major teaching affiliate of Rush-Presbyterian-St. Luke's Medical Center, seeks family practitioners and obstetricians. Opportunities include private practice, solo, partnership, practices for sale, salaried positions. Individualized comprehensive financial package. BE/BC family practice; OB/BC family practice; OB/GYN. Forward CV: Physician Affairs, 3249 S. Oak Park Avenue, Berwyn, IL 60402. (10)

FLORA:
Small, progressive hospital in southern Illinois seeks family practitioner. Beautiful small town, scenic area, yet only an hour's drive from major metropolitan areas. Financial assistance and office space available. Contact: John E. Monnahan, Administrator, Clay County Hospital, 700 North Mill, Flora, IL 62839; (618) 662-2131 ext. 228. (9)

HAZEL CREST:
South Suburban Hospital has immediate opportunity for board certified, or board eligible family practitioner/internist. Physician will assume control of well established practice of retiring physician. Relocation allowance; loan guarantees: marketing support available. Will consider candidates currently finishing residency. For this and other practice opportunities, direct C.V. to Joe Dwyer, Vice-President Marketing, South Suburban Hospital, 17800 S. Kedzie, Hazel Crest, IL 60429. (9)

QUAD-CITIES
Emergency medicine/ambulatory care opportunity, aggressive private group covers brand new (construction completed March 1988) level II trauma center and ambulatory care center. Compensation highest in area. Immediate opening. Contact Premier Emergency Group, P.C. 3024 Chateau Knoll, Bettendorf, IA 52577. Phone: (319) 332-5927. (9)

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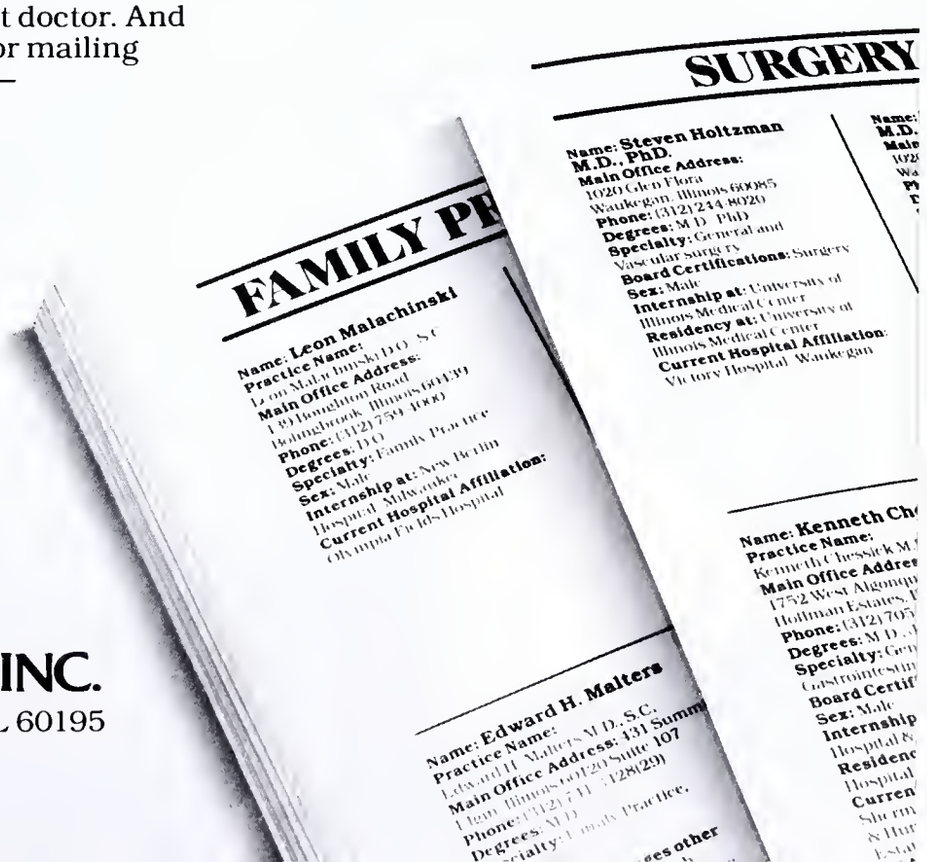
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MEMBERSHIP FORUM

Membership Forum is intended to serve as a communication tool for ISMS membership. The editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. ISMS cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.

Correspondence should be addressed to: IMJ, Twenty North Michigan Avenue, Suite 700, Chicago 60602.

DuPage County-Chicago Medical School Preceptorship Program

To the Editor:

It is hard to believe that this collaborative effort between the medical school and the county medical society has passed its twentieth year of operation. Since that time 72 of the county's physicians have allowed over 674 Chicago Medical School students to "shadow" them in their daily practice.

The key to the continuing success of the program has been the excellent cooperative effort between the staff of the DuPage County Medical Society and that of the Chicago Medical School. ◀

Sincerely,
Norman M. Frank, M.D.
Clarendon Hills

Just A Decimal Point . . .

To the Editor:

This is in regard to the "Doctor's News" column from the July *Illinois Medical Journal* (Volume 174, Number 1, 1988).

As I read this article, eight billion dollars for administration out of a total of $50 billion in expenses is very close to 16%, not 1.7%. Is this a typographical or a mathematical error?

Under Part B, you mention $29.9 billion total and report $9 billion as an administration cost. This would be 30% not 3%.

If it is indeed 30%, I think every physician in the country should be outraged. ◀

Sincerely,
James E. Gottemoller, M.D.
Streator

Editor's Note: The July "Doctor's News" incorrectly stated some data regarding Medicare administrative expenses during fiscal year 1987. The report should have indicated that: Medicare Hospital Insurance Trust Fund (Part A) expenditures totalled $50.0 billion in 1987. Of this, $0.8 billion, or 1.7%, was spent on administrative expenses. The Medicare Supplementary Medical Insurance Trust Fund (Part B) expenditures totalled $29.9 billion in 1987, and $0.9 billion, or 3.0% of this went to administrative expenses. Overall Medicare administrative expenses were $1.7 billion or 2.1% of Medicare health care expenses.

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ISMS All Member Conference
November 4-5

Spotlight On Illinois

The ISMS All Member Conference will be held at the Springfield Radison-Renaissance Hotel on November 4-5. Seminars are structured to bring the Illinois physician up to date on news and trends in medical practice.

The 1988 All Member Conference will be held in the heart of the Land of Lincoln, and Honest Abe has agreed to host the opening reception, 7:00-9:00p.m. on Friday, November 4. Mr. Lincoln will greet attendees at the Old State Capitol with a string quartet. His entourage will include several ladies in Civil War dress, who will serve hors d' oeuvres. Leaders from government and the legislature will join physicians for informal conversation.

Saturday's schedule begins with an 8:00 a.m. breakfast hosted by the ISMIE Network and featuring an overview of recent events in professional liability insurance. The free give-and-take which characterizes the breakfast sets the tone for the day's events.

The general session begins at 9:00a.m. with a panel discussion of the federal Health Care Quality Improvement Act. Retired Federal Judge Frank McGarr and ISMS General Counsel Saul Morse will discuss this new federal law and its far-reaching implications for peer review. The Act provides for a national discipline data bank, and details requirements for due process and mandatory reporting. Antitrust implications and immunity protections will be covered.

Physicians will opt for two of three breakout sessions filling out the morning's agenda. ISMS communications consultant Toba Cohen will seek comment and criticism on the Society's new flagship publication, *Illinois Medicine.* A second breakout option on the upcoming elections will include projections on how the General Assembly will stack-up after November. The third breakout will feature a progress report on the Resource Based Relative Value Study.

The luncheon speaker is Dr. Uwe Reinhardt, a James Madison Professor of Political Economy at Princeton University. Dr. Reinhardt's acerbic wit and cutting insights make for a fast-paced, intellectually-stimulating presentation.

The AMA fault-based medical lia bility proposal will be explained b Alfred J. Clementi, M.D., in th general session following lunch. Dr Clementi, a member of the AMA' Professional Liability Advisory Pan el, will describe this proposec means to resolve medical liabilit disputes.

The "Anatomy of an ISMIE Claim" promises to be engaging and informative. Defense attorneys and ISMIE claims examiners will enact the progress of a claim from filing to resolution. Physicians will gain a sense of the Exchange claims management system and the risk management issues which underlie medical malpractice liability.

Conference registration fees of $50 for ISMS and ISMS Auxiliary members and $100 for non-members will cover all materials and refreshments. Those who wish to attend may complete and return the coupon on the facing page or await a more complete program to arrive by mail.

Illinois State Medical Society
All Member Conference

Saturday, November 5, 1988
The Radisson-Inn Nisqually Hotel
Springfield, Illinois

s it true that new federal egislation will make funda- nental changes in peer review nd physician discipline?

Iow volatile is the Illinois nedical malpractice environ- nent today?

Vhat's the bottom line for llinois physicians on the Resource Based Relative Value Study?

Vhat can I do to assure that *"Illinois Medicine"* is all that t can be?

Spotlight on Illinois



What does the health care economist have to say about American medicine in the year 2000?

How will the 1988 elections affect health care legislation in Illinois?

What happens when a physician files a claim on his medical malpractice insurance policy?

Can the AMA Fault-Based Medical Liability Proposal find support?

Attend the ISMS conference—we'll spotlight the facts!

To register for the ISMS All Member Conference, please complete and return this form with payment of the registration fee. The fee is $50 for ISMS and ISMS Auxiliary members, and $100 for non-members. All fees are waived for residents and students. Checks should be made payable to the Illinois State Medical Society.

Please print or type

Name

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County Medical Society

Primary Hospital Affiliation

☐ Please send a sleeping room reservation card.

I ☐ will (☐ will not) attend the Saturday luncheon.

I ☐ will (☐ will not) attend the Friday reception.

Breakout Session Preference
Choose two:

☐ Illinois Medicine

☐ Election Projections

☐ RBRVS

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

New mothers showed a three-fold increase (34%) in the incidence of exacerbation of multiple sclerosis in the postpartum stage, particularly within the first three-month period, compared to the pregnancy period (10%). The rate of exacerbation increased 38% in breast feeding mothers and 31% in non-breast feeding mothers. This difference was not statistically significant. The average time period for exacerbation to occur was similar in both groups: 3.0 months in the breast feeding group compared to 3.1 months in the non-breast feeding group. (Nelson, L., *et al.; JAMA* 259:23, 3441-3, 1988)

The long-term effectiveness of a smoking cessation program based on education, behavior modification, and group support was evaluated and participants were followed. Twenty-two percent were smoke-free after one year and continued to be so after six years. Factors related to a higher rate of smoking cessation were a white-collar occupation, having previously stopped smoking for more than one month, being male, and the incentive to quit because of health concerns. (Hurt, R., *et al.; Mayo Clin Proc* 63:7,681-690,1988)

A group of uncomplicated post-myocardial patients receiving occupational work evaluation was compared to a group treated in the conventional manner. Return to full-time employment and morbidity were evaluated in these two groups. The occupational work evaluation consisted of a symptom-limited treadmill test performed 23 ± 3 days after myocardial infarction and a recommendation to return to work within the next two weeks. Evaluation of both groups at six months showed 92% of patients who received intervention returned to work after an average of 51 days of convalescence, and 88% of patients with usual care were at work after an average of 75 days. Recurrent cardiac events were noted in 14 patients with intervention of occupational work, and in 13 patients receiving conventional care. The benefits were predominantly the increased earnings of those returning at an earlier period. (Dennis, C., *et al.; JAMA* 260:2, 214-220,1988)

Integral bone mineral content of 35 sedentary, post-menopausal women receiving oral calcium was determined using a dual photon absorptiometer. Some of these women received weight-bearing exercise therapy three times weekly (walking, jogging, stairclimbing) at 70%-90% of maximal oxygen uptake; the remainder maintained their normal lifestyles. The weight-bearing exercises led to a significant increase in bone mineral content (5.1%-6.1%), and when threshold exercises ceased, the bone mass reverted to near baseline levels. (Dalsky, G., *et al.; Ann Int Med* 108:6,824-828,1988)

Hypocalcemia appears to be time-dependent and due essentially to extracellular complexing of calcium in patients with cardiac arrest. Blood ionized levels, total calcium levels and pH were obtained in 12 patients as they were ventilated and given external cardiac massage after having an out-of-hospital cardiac arrest. On admission they had marked ionized hypocalcemia (mean 0.67 ± 0.22mmol/L), but normal total calcium levels. There was a positive correlation between pH and ionized calcium levels. Further work is needed to determine if patients who have out-of-hospital cardiac arrests benefit from calcium administration. (Urban, P., *et al.; Ann Int Med* 109:2, 110-113,1988)

A blood pressure survey was conducted on 2,122 subjects 35 years of age or older. Hypertension was diagnosed when the patients had a systolic blood pressure of 160mmHg or more, a diastolic blood pressure of 95mmHg or more, or a history of hypertension. Hypertension was found in 31% of the group and 12% were not aware they were hypertensive. Among the patients with a history of hypertension, 77% were taking antihypertensive medication of diuretics alone or in combination with others, and of these, 22% were poorly controlled. They showed systolic pressures over 160mmHg and diastolic pressures over 96mmHg. Side effects from medications were noted in 12% of subjects taking antihypertensive medication. (Phillips, S., *et al.; Mayo Clin Proc* 63:7,691-699,1988)



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THE INFORMED PHYSICIAN

THE INFORMED PHYSICIAN KNOWS WHAT QUESTIONS TO ASK, WHAT ISSUES TO RESOLVE AND WHEN TO CONSULT AN ATTORNEY, ACCOUNTANT OR ACTUARY WHEN CONSIDERING CONTRACTING WITH ALTERNATIVE DELIVERY SYSTEMS. THE ISMS OFFICE OF CONTRACTUAL SERVICES PRESENTS "THE INFORMED PHYSICIAN" AS AN EDUCATIONAL TOOL DESIGNED TO ILLUSTRATE, THROUGH REAL-LIFE SITUATIONS, THE SIGNIFICANT LEGAL AND ECONOMIC ISSUES WHICH FREQUENTLY ACCOMPANY CONTRACTS FOR THE DELIVERY OF HEALTH CARE, AND TO ALERT PHYSICIANS OF WAYS IN WHICH CONTRACTS MAY AFFECT THE PRACTICE OF MEDICINE.

Talk About Mysteries

BY JUDEE GALLAGHER, J.D./CHICAGO

"Physician will be paid an unknown amount for rendering unspecified services if these services are authorized according to unstated criteria."

Alternative delivery systems generally offer different contracts to primary care and specialist physicians. If capitation payments, ambiguous incentive pools and a "gatekeeper" role make primary care contracts difficult to evaluate, similar issues exist in specialist contracts. Initially, it's a good idea to determine what is meant by the classification "primary care" and "specialist" physicians within a system. The definition is not always the same in every contract. For example, some contracts classify obstetrics/gynecology as primary care, while others make it a specialty. An obstetrician classified as a specialist may only receive high risk referrals, while one classified as a primary care physician may render a broader spectrum of care. In addition, the medical director may permit primary care physicians to also participate as specialists.

A widespread problem with all contracts stems from the inadequate definition of key terms. When *covered service, fee schedule* and *authorized service* are not clearly defined, the agreement may boil down to this: "Specialist will be paid an unknown amount for rendering unspecified services if these services are authorized according to unstated criteria."

A central issue is the definition of *covered service.* Many contracts simply require the physician to provide the covered services within the physician's specialty, without naming what those services are. Since payment for covered services is based on the plan's fee schedule, it is impossible to evaluate the contract's financial impact without a list of services covered and those that are excluded. Many contracts also prohibit you from billing the patient for services which are not covered unless you inform the patient of the charge prior to treatment.

After reviewing a list of covered services, the next step is determining how a covered service becomes *authorized.* Plans generally only pay for authorized covered services. Presumably, a covered service is *unauthorized* if you fail to follow the utilization review procedures, including prior approval, or if you follow the procedures but pre-certification is denied based on medical necessity grounds. In the latter situation, you have a legal and ethical responsibility to provide the service regardless of the plan's determination if to withhold care would diminish your "standard of care." This is so even if the contract both obligates the HMO to pay *only* for authorized services and prohibits you from billing the patient for unauthorized covered services.

These troublesome issues confront the specialist when a recommended treatment is covered but the full range of procedures is not authorized. Consider this situation: A dermatologist receives a referral for the removal of a particular growth, but the plan refuses to authorize (and therefore pay for) a pre-operative biopsy. If the biopsy is necessary to protect the quality of care rendered, it must be performed. Cost containment efforts do not diminish the "standard of care" you owe your patients. Determine what your most frequently performed procedures are. Will the plan pay for all the steps necessary in a particular course of treatment?

If you have purchased expensive equipment, find out whether the plan provides additional compensation for its use. Can you maintain your "standard of care" without using the equipment? If you provide highly-specialized care and believe the plan hospitals are inadequate within your specialty, will the plan authorize treatment in other hospitals?

Answers to these questions provide a basis for making an informed decision regarding participation. The more mysteries you solve before you sign, the fewer dilemmas you'll face during the contract year. ◀

Judee Gallagher, J.D., is a Chicago private practice attorney retained by the ISMS Office of Contractual Services since 1985.

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...But only one–Associated Physicians Insurance Company–offers "prior acts" coverage so you don't have to purchase expensive "tail coverage" to join us. And because APIC is owned and directed by Illinois physicians, you can be sure that coverage is delivered with *your* needs and concerns in mind.

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for better patient compliance



AXID®
nizatidine capsules

Brief Summary Consult the package insert for prescribing information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s., after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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Surgery of the Ascending Thoracic Aorta

By Fredrick B.Y. Hoy, M.D., Robert C. Gomez, M.D., Dale M. Geiss, M.D., and James R. Munns, M.D./Peoria

Lesions involving the ascending thoracic aorta present challenging therapeutic problems to the cardiovascular surgeon. Historically, surgical therapy of these lesions has been associated with great concern. The proximity of major structures, including the aortic valve, coronary arteries, and the great vessels from the aortic arch, as well as the friable nature of the ascending aorta, have contributed to complications. However, modern surgical skill, new prosthetic materials and active support from consulting and ancillary staff can allow repair of lethal lesions with acceptable morbidity and mortality rates.

Between January 1, 1983 and December 31, 1986, 19 patients (12 males and 7 females) with an age range of 31-75 years underwent surgical therapy for lesions of the ascending aorta. Three patients were operated on for ascending aortic aneurysms (Group 1). The remaining 16 patients were operated on for Type A dissection (Group 2). (Table 1)

Group 1
Ascending Aortic Aneurysm

Three patients underwent surgical correction of ascending thoracic aortic aneurysm. Two had annuloaortic ectasia with aortic insufficiency. One had marked poststenotic dilatation secondary to aortic stenosis. All three patients underwent composite graft replacement of the aortic valve and ascending aorta with a valved conduit, with reimplantation of the coronary arteries as originally described by Bentall and DeBono.[1] The Bjork-Shiley aortic graft valved prosthesis was used in all patients.

Group 2A
Acute Type A Dissection

Twelve patients presented with acute type A dissection, nine of whom had aortic insufficiency. The three patients who did not have aortic insufficiency underwent replacement of the ascending aorta with a ringed intraluminal sutureless prosthesis. The patients with aortic insufficiency underwent various procedures depending upon the state of the aortic root. Two patients underwent composite graft replacement of the aortic valve and ascending aorta with reimplantation of the coronary arteries because of annuloaortic ectasia. Four patients underwent aortic valve plication and replacement of the suprasinusoidal aorta with the intraluminal prosthesis. The remaining three patients underwent composite graft replacement of the ascending aorta and aortic valve with reimplantation of the coronary arteries and distal replacement of the ascending aorta with a sutureless intraluminal graft.

Group 2B
Chronic Type A Dissection

Four patients were treated for chronic type A dissections, two with aortic insufficiency and two with

Table 1
Ascending Aortic Operations

Ascending Aortic Aneurysm	
Group 1 (n = 3)	
No AI*	1
AI	2
Type A Dissection	
Group 2A (n = 12) Acute	
No AI	3
AI	9
Group 2B (n = 4) Chronic	
No AI	2
AI	2

**AI = aortic insufficiency*

competent aortic valves. Four different procedures were performed as outlined below.

Results

The overall operative mortality rate was 10.5% (2/19).

In group one patients with ascending aortic aneurysms, the average crossclamp time to perform composite graft replacement of the ascending aorta and aortic valve with reimplantation of the coronary arteries was 89.7 minutes. The average postoperative hospital stay was 7.7 days. There were no significant postoperative complications. (Table 2)

In group 2A, three patients had acute type A dissections without aortic insufficiency. Two patients underwent intraluminal graft replacement of the ascending aorta with an average crossclamp time of 31 minutes. One patient underwent a modified Bentall procedure with a crossclamp time of 88 minutes. Two patients were noted to have confusion postoperatively; multiple small intracerebral infarcts were demonstrated on CT scan. Preoperatively, both of these patients presented with syncope, confusion, and loss of consciousness. The average postoperative hospital stay was 15 days.

Of the nine patients treated for acute type A dissection with aortic insufficiency, crossclamp times ranged from 36 minutes for intraluminal graft replacement of the ascending aorta with aortic valve plication to 132 minutes for proximal replacement of the aortic valve and ascending aorta with the composite valved conduit with intraluminal graft replacement distally. One patient in this group died six days postoperatively. This patient had a previous ligation of a patent ductus arteriosus and succumbed from hemorrhage due to adhesions from the distal false lumen of the descending thoracic aorta and the left lung.

The average postoperative hospital stay in this group of patients was 40 days. They had the highest incidence of postoperative complications. These included four patients requiring hemodialysis for acute renal failure, two patients requiring prolonged intubation for respiratory failure, three patients requiring pericardial drainage procedures, and two patients with postoperative central nervous system deficits, one of whom had had central nervous symptoms preoperatively.

Table 2
Postoperative Complications

	Group 1	Group 2A		Group 2B
	(n = 3)	No AI* (n = 3)	AI (n = 9)	(n = 4)
Deaths	0	0	1	1
CNS deficit	0	2	2	1
Renal failure	0	0	4	0
Respiratory failure	0	0	2	0
Pericardial effusion	0	0	3	0
Re-op for bleeding	0	0	0	0
Average post-op stay (days)	7	15	40	12

**AI = aortic insufficiency*

The four patients in group 2B, chronic type A dissections, underwent four different procedures. One patient underwent composite graft replacement of the ascending aorta and aortic valve for severe aortic insufficiency and an enlarging ascending aorta. One patient underwent intraluminal graft replacement of the ascending aorta distally, with proximal composite graft replacement of the aortic valve and ascending aorta for aortic insufficiency and expansion of the false lumen. One patient with an enlarging ascending aorta, but no aortic insufficiency, underwent intraluminal graft replacement of the ascending aorta. The fourth patient, with an enlarging ascending aorta, underwent tube graft replacement of the ascending aorta with intraluminal graft replacement distally.

In two of these patients, there was some difficulty in ascertaining the proportion of flow in the true lumen and the false lumen distally, particularly while on cardiopulmonary bypass. Accordingly, in one patient the distal anastomosis was performed to maintain perfusion to both the true and false lumens. In the other three patients, all flow was redirected back into the true lumen distally. There was one death. It occurred in one of the patients in whom we were uncertain about perfusion of the true lumen from the femoral artery while on cardiopulmonary bypass. The patient sustained a severe central nervous system insult and succumbed without regaining consciousness. The average postoperative stay for the other patients was 12 days. There were no reoperations for bleeding in any group.

Discussion

Aneurysms of the ascending aorta are most frequently due to cystic medial necrosis. Other causes include atherosclerosis, dissections,

yphilis, and giant cell aortitis. They ıay result from poststenotic dilata- ion secondary to severe aortic ste- ıosis. The associated aortic insuffi- iency is a result of either dilatation f the aortic root and annuloaortic ctasia or dissection of the noncor- ıary leaflet attachment to the aor- ic wall with prolapse of the cusp ıto the left ventricle.

Composite graft replacement of he ascending aorta and aortic valve xcludes all abnormal tissue from he aortic annulus to the innomi- ıate artery. Older reports of con- entional aortic valve replacement ınd supracoronary ascending aorta eplacement for this disease were ıttended with high rates of postop- rative bleeding and late aneurysm ormation in the sinus of Valsalva.[2] Reoperation rates for bleeding for he composite graft technique are n the range of 12%.[3] Operative nortality for elective replacement f the ascending aorta and aortic alve without acute dissection anges from 2.9% to 10%.[2-5] A small ut definite incidence of pseudo- ıneurysm formation at the coro- ıary ostial anastomosis has been eported in follow-up in larger eries.[3] This underscores the need or careful lifetime follow-up in hese patients. We believe compos- te graft replacement of the ascend- ng aorta and aortic valve with reim- plantation of the coronary arteries s the treatment of choice for patients with ascending aortic aneu- rysm of the thoracic aorta second- ary to annuloaortic ectasia.

Medical management of acute type A dissections is attended by an unacceptable mortality approach- ing 95% at three months. The major causes of death include pericardial tamponade from intrapericardial rupture of the false lumen, and congestive heart failure from aortic insufficiency. Accordingly, the goals of surgical therapy include elimination of the false lumen in the ascending aorta, precluding intra- pericardial rupture, and correction of aortic insufficiency.

The operative treatment of acute aortic dissections has been associ- ated, in the past, with a high mortal- ity, mostly due to bleeding from anastomotic suture lines into friable tissue. Operative mortality rates, ranging from 16.7% to over 50%, have been reported.[5-8] The pres- ence, preoperatively, of certain major complicating factors mark- edly increases the risk. These include pleural rupture, aortic insufficien- cy, pericardial rupture, pericardial tamponade, loss of a peripheral pulse, loss of renal or visceral perfu- sion, myocardial infarction, cere- brovascular accident, shock, and anuria.[6]

The intraluminal prosthesis, by eliminating suture lines in the fria- ble aortic tissue, has markedly decreased operative morbidity and mortality from bleeding.

The presence of aortic insuffi- ciency dictates either repair or replacement of the aortic valve, or composite graft replacement of the aortic valve and ascending aorta if aortic root dilatation is present.

The majority of deaths from acute dissection are caused by local catastrophic complications. Surgi- cal replacement of limited segments of the aorta containing those most severely damaged can effectively prevent these deaths; but surgical treatment does not cure the disease. Ideally, exclusion of the intimal tear and primary repair of the involved segment of the aorta re-establishes central aortic flow and effectively converts the distal false lumen, if present, into a contained hemato- ma. This allows for complete heal- ing of the dissection.

The intimal tear is not always resected if it occurs in the aortic arch or descending thoracic aorta. This, reportedly, is not correlated with operative mortality, late reop- eration rate, late functional result, or late mortality.[6] A patent distal false lumen may persist, especially if the patient is on anticoagulation treatment because of a prosthetic valve. Again, this does not correlate to late functional status or the need for reoperation.[7]

Despite the increased survival rate, morbidity remains high, with respiratory insufficiency reported in 27% of cases and acute renal failure in approximately 20% of cases. Postoperative hospital stays are prolonged, ranging from 2-3 weeks or longer.[8]

The indications for surgery in chronic type A dissections include symptoms secondary to the dissec- tion or expansion of the ascending aorta. With chronic dissections, important aortic branches may be dependent upon perfusion solely from the false lumen, which com- municates with the true lumen via the intimal tear or distal fenestra- tions. The goals of surgical therapy for chronic type A dissections are the correction of aortic insufficien- cy and elimination of the false lumen in the ascending aorta. As branches of the aorta may be dependent upon supply from the false lumen, it may not be possible to direct all of the flow into the true lumen distally. Careful arteriog- raphy preoperatively may help to resolve the dilemma. Operative mortalities, in the range of 2.5% to over 60%, have been reported.[5-7]

Summary

Improved surgical therapy results for lesions of the ascending aorta have been dependent upon the development of new graft pros- theses, improved myocardial pro- tection, and advances in hemostasis. Composite graft replacement of the ascending aorta and aortic valve, with reimplantation of the coronary arteries, is the treatment of choice for lesions involving the aortic root and ascending aorta. We believe that the use of the intraluminal prosthesis has helped improve results in Type A dissections, partic- ularly by shortening myocardial ischemia time and decreasing post- operative bleeding. However, acute Type A dissection with aortic insuf- ficiency continues to be associated with significant postoperative mor- bidity. Further studies are necessary to determine the efficacy of this mode of therapy in the long term.

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An Historical Perspective of the Pre-Antibiotic Era

The Evolution of Otitis Media Treatment in Illinois

By James E. Wiedeman, M.D., and Jean A. Taylor-Wiedeman, M.D./Tokyo, Japan

In the pre-antibiotic era, otitis media was a source of appreciable morbidity and mortality. We generally do not encounter major complications from this disease today. To emphasize the historical gravity of such simple infections, we present a chronological record of the pre-antibiotic era of otitis media treatment in Illinois from 1871 to 1924.

Early in Illinois medical literature, Dr. Samuel J. Jones stated that "Diseases of the ear seemed devoid of interest and that treatment was unsatisfactory to a marked degree."[1] An awakening interest to the seriousness of middle ear infections prompted Dr. Jones, a professor of ophthalmology and otology at the Chicago Medical College, to address current treatment modalities for middle ear infection at the 1871 Illinois State Medical Society meeting.[1]

Dr. Jones felt that blockage of the eustachian tube usually preceded middle ear infection. To open the tube, he advocated frequent use of the Valsalva maneuver. If Valsalva failed, he recommended Hinton's method for treating middle ear suppurations: "To rid the middle ear of altered secretions there accumulated, incise the membrane tympani and wash that cavity through the external meatus, passing a stream down through the eustachian tube and out through the nares, by inclining the head of the patient forward, and having him keep his mouth open."[1] This latter maneuver prevented flushed-out secretions from entering the throat and mouth.

Dr. Jones' concern was reiterated in 1876 by Dr. F.C. Hotz of Chicago as he addressed Illinois State Medical Society members. Dr. Hotz was alarmed at the indifference of both physicians and laymen to "such a morbid process in the immediate vicinity of the brain, it's membranes, and the cerebral sinuses."[2] He presented two cases of suppurative otitis media with fatal complications in hope of establishing awareness to the seriousness of the problem. (*Editor's Note:* See p. 147 for a case summary, which exemplifies the management of suppurative otitis media in 1876.)

In 1880, W.T. Montgomery, M.D., professor of ophthalmology and otolaryngology at the Woman's Medical College of Chicago, contributed more advanced recommendations, especially for pain control. For treatment of acute uncomplicated suppuration of the middle ear, he agreed that thorough cleansing with a warm water douche was needed. But if pain was not controlled by the douche, "local blood-letting by means of the artificial leech should be resorted to." The artificial leech, which is similar to the small cupping glass (Figure 1), was used to draw blood to the surface of the skin. In preparation for its use, air was evacuated by either applying heat over an open flame or burning paper or gauze inside the glass. This created a partial vacuum which facilitated blood withdrawal in wet cupping where the skin had previously been scarified. If this fails to relieve pain, anodynes of opium, chloral hydrate, and potassium bromide should be used. In addition, he advocated inflation of the eustachian tubes by the method of Valsalva. "By these inflations, the tubes are opened, and any matter that may not have been removed by the douche is forced out."[3]

For chronic suppurative infections, Dr. Montgomery advocated thorough cleansing of the ear, instillation of mild astringent solutions (zinc sulfate, carbolic acid, and lead acetate) and "active stimulation to the parts three times per week." Excessive overgrowth of granulation tissue should be destroyed by nitrate of silver. He felt that in cases of perforation of the ear drum, small paper discs cut from ordinary writing paper should be placed over the perforation.

Finally, the popular practice of poulticing for pain was condemned



Figure 1
Cupping glass, circa 1880.

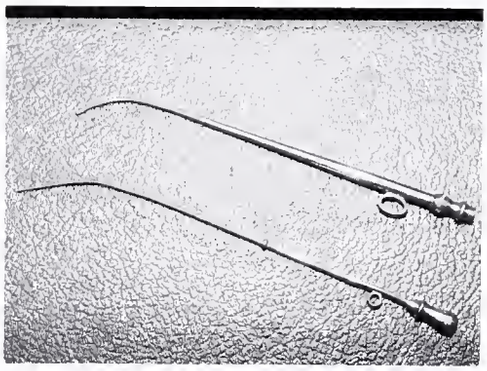


Figure 2
Eustachian catheters, circa 1890.

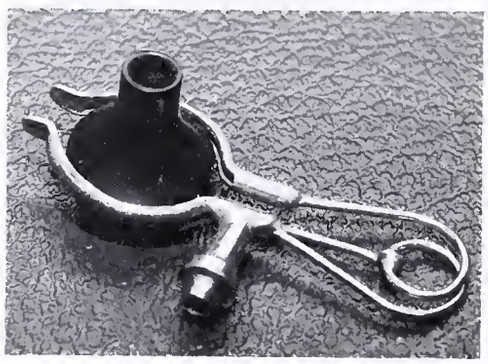


Figure 3
Zinc ionization electrode, circa 1920.

by Dr. Montgomery. He felt that poulticing defeated the all-important factor in the treatment of this disease: cleanliness, and that "the occlusive nature of a poultice tended to retain middle ear secretions."[3]

Toward the end of the 1880s, Seth Bishop, M.D., of Chicago, presented, "New Methods of Treating Diseases of the Middle Ear."[4] He proposed the concept that drainage of secretions down the tube into the pharynx would be more effective than the reverse procedure of Valsalva inflation. "This is the reverse of the Valsalvian experiment. The patient closes the mouth and nostrils and exhausts the air in the nasopharynx by a strong inspiratory effort. This causes the ejection of the column of air, and the secretions from the eustachian tube and tympanum into the pharynx."[4] Although this maneuver was less invasive than the previously mentioned Hinton's method, more severe techniques were required for tenacious secretions. First, a eustachian catheter (Figure 2) was introduced through the nares to cannulate the eustachian tube. Next, a vulcanite syringe was attached to the catheter, followed by gentle traction in order to evacuate the contents.

The Twentieth Century

Around the turn of the century, conservative medical advancements in the treatment of suppurative middle ear infections were minimal. However, as surgical techniques became more sophisticated, more radical procedures for chronic ear infections became popular.

Dr. A.E. Prince of Springfield addressed the operative treatment of discharges from the ear in 1906. In the event that conservative treatment failed, he felt that therapy should be followed by radical surgical removal of the mastoid process and other affected regions. "The operator must remove the cortex and all the mastoid cells down to the inner table to within a millimeter of the dura mater, yet not injure the horizontal semicircular canal, the lateral sinus, the cochlea, fenestra ovalis or rotunda, the facial nerve, or the carotid artery."[5]

Dr. Prince encouraged examination of smears of pus in every case. "The streptococcus demands early attention, the pneumococcus and staphylococcus are regarded as less urgent."[5]

In 1908, E. Russel Ogden M.D., instructor of otology at Northwestern University Medical School, Chicago, described current medical management of acute otitis media. He advocated bed rest, saline cathartics, anodynes, and aconite for fever. For instillation, Dr. Ogden recommended morphine, cocaine, atropine, and carbolic acid; oily solutions were strongly discouraged. "In a few hours, if you fail to abort the pain, freely incise the tympanic membrane." He advocated doing this with a strictly aseptic technique. Afterward, frequent irrigation with an antiseptic solution was advised. He also promoted bacteriological classification.[6]

Up to this time, little change in management was seen other than the elimination of oily installations, the introduction of more stringent aseptic techniques, and the treatment of fever.

In 1920, Dr. G. Shambaugh described the current management of chronic suppurative ear disease in an attempt to more precisely define the indications for radical surgery. He concluded that simple conservative measures be used for those cases with only mucous membrane involvement. When bony erosions occurred, he felt that aggressive surgical debridement was mandatory.[7]

As mentioned previously, rapid interest in the bacteriological etiology of infectious disease developed early in the 1900s. However, no clinically proven antimicrobial agent was found to be effective, although innovative treatment modalities continued to appear.

In the early 1920's, Dr. C.E. Yerger, of Chicago, designed a zinc ionization electrode for use in chronic otitis media. (Figure 3) He utilized this treatment in private practice and at the Illinois Charitable Eye and Ear Infirmary of Chicago. The ionization of zinc allegedly led to coagulation of albumin and penetration of bacteria with subsequent eradication of the infection. The patient was instructed to lie on the unaffected side while a warm solution of zinc was instilled into the exposed meatus. The electrode with the positive current was then inserted into the ear while the negative electrode was applied to an arm or leg. The current was acti-

Otitis Media, circa 1876

March 9, 1876. A 40-year-old male presented with chronic neglected otorrhea. "In the beginning of March, the weather being very damp, he caught a severe cold, which caused an acute inflammation in the already affected ear."

Memorandum by Dr. Hotz: "Patient pale, worn out, but not feverish; violent pain in the left side of head; mastoid region neither tender nor puffy; external meatus moistened by a moderate and thin puriform secretion. The lower portion of the membrana tympani is destroyed, and the upper portion is greatly thickened and rigid, the entrance to the tympanic cavity is narrowed to a small horizontal slit which of course neither permits inspection of the middle ear nor discharge of the puriform secretion."

A vertical incision through the remaining upper portion of the membrana tympani was made and leeches were applied to the lower part of the mastoid process. The patient was advised also to fill the ear often with warm water. Two days later, acute symptoms had subsided; the patient had no pain, and he could sleep again. "And at the office I applied to the middle ear a strong solution of carbolic acid with tincture of iodine, and later, a solution of carbolic acid in olive oil. These remedies were introduced by means of a probe, the point of which was wrapped up with cotton."

"And as to his general health, Mr. BL at first seemed to improve. What he complained of mostly was that he could not read half a column of a newsprint without getting a headache. Since the middle of March, he had profuse night sweats, and on several days he stated to me that in the preceding night he woke up with a pain in the whole left side of his head which responded to a warm poultice. His wife, however, told me that during these same nights Mr. BL was somewhat delirious". Then on the night of March 31, he had a violent headache and fell into a profound sleep with stertorous respirations. The tongue was dry, the pupils were very small and remained so in the dark. The discharge from the ear had ceased entirely. April 3: The patient expired.

Summary from autopsy: "Death due to meningitis. Mechanism: When the cribriform floor of the internal auditory canal was broken down and the pus could, without difficulty, pass along the acoustic nerve into the subarachnoid spaces, the meningitis was kindled, to rapidly exhaust the vital power of the patient."[2]

vated to 2-3ma. for 10 minutes. "Often the suppuration will cease immediately and in 24 hours the cavity will be dry and free from any evidence of inflammatory trouble."[8]

Compared to previous therapeutic modalities, this technique was innovative for its time. Nevertheless, its interest was short-lived, since effective antibiotics soon revolutionized the treatment of otitis media.

Conclusion

Widespread application of antibiotic agents in the 1920s and 1930s revolutionized the treatment of infections such as otitis media. Nevertheless, the work of those aforementioned pioneers in Illinois medical history should not be forgotten. ◀

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In a Community Practice

Abdominal Aortic Aneurysm Repair

By Adam H. Romeiser, Jr., M.D., George A. Olander, M.D., Donald M. Coder, M.D., And Lionel W. Ganshirt, M.D./Lake Forest

It is generally accepted that abdominal infrarenal aortic aneurysms should be repaired electively. The mortality rate with elective repair is 5% or less in large studies, whereas mortality with repair after rupture remains at about 50%-70% nationally.[1] Without repair, the five-year survival of patients with abdominal aortic aneurysm is 19%, and 63% of patients die of aneurysm rupture.[2]

The risk of rupture varies, depending upon the size of the aneurysm. Aortic aneurysms under 6cm have a 4%-20% risk, those over 6cm have a 40%-80% risk. A study published in 1984 by Bernstein[3] showed a growth rate of 0.4cm per year for aneurysms 6cm or smaller. We feel that if an aneurysm is 4cm or greater by ultrasound evaluation, repair should be performed if the patient has no actual contraindications. These would include myocardial infarction in the past six months, intractable angina, severe chronic obstructive pulmonary disease (COPD) with dyspnea at rest, chronic renal insufficiency (BUN greater than 80 or creatinine greater than 3.0), or cancer with poor prognosis. Senility might also be considered a contraindication.

We reviewed the last 100 consecutive aneurysms repaired in our community practice to determine how the mortality compares with the reported national rates, and to determine the incidence of emergency operation. These operations were performed in three community hospitals by a group of four vascular surgeons. All hospital charts were reviewed for the last 100 consecutive cases performed from 1975 through 1985.

Results

We classified cases into three groups: elective (59); urgent (symptomatic aneurysm with acute expansion causing back, abdominal or groin pain) (13); and emergency (because of rupture) (28). There were no deaths in the 59 patients operated electively, two deaths in the 13 patients operated urgently (15% mortality), and 11 deaths in the 28 patients operated after rupture (39% mortality). Both of the patients who died following urgent operation without rupture did so from cardiac causes. One died ten days postoperatively from ventricular arrhythmia and one at six days after surgery for myocardial infarction. Two patients in the ruptured group died from hypovolemia and cardiac arrest in the operating room and four died from cardiac arrest in the first postoperative day. The other five deaths occurred 2-18 days postoperatively from renal failure, sepsis, ARDS, and combined respiratory and congestive heart failure. Complications in the three groups are summarized in Tables 1-3. Morbidity was 32% in the rup-

Table 1
Ruptured Emergency Group

Patient	Complications
1	Respiratory failure
2	Respiratory failure and cardiac arrest, stroke
3	Pulmonary embolus
4	Disseminated intravascular coagulation
5	UGI bleeding, prolonged ileus causing caecal perforation
6	Wound infection, wound eviseration, azotemia, pneumonia, hepatitis, congestive heart failure
7	Emboli to foot causing gangrene tips of several toes
8	Left femoral embolus
9	Right femoral embolus, compartment syndrome and ischemic colitis

Table 2
Urgent Symptomatic Group

Patient	Complications
1	Respiratory insuffiency secondary to COPD (intubated 3 days)
2	Congestive heart failure, mild azotemia, respiratory insuffiency and pneumonia

Table 3
Elective Non-Ruptured Group

Patient	Complications
1	Cystitis
2	Prolonged ileus of 2 weeks duration
3	Hemolytic reaction with jaundice
4	Severe delirium tremens and atelectasis
5	Cardiac arrhythmias and ileus of 10 days duration
6	Congestive heart failure
7	Wound seroma
8	Renal failure (reversible) and pneumonia
9	Small bowel obstruction secondary to adhesions
10	Embolus to right great toe
11	Bleeding duodenal ulcer necessitating antrectomy and vagotomy

There were no cases of graft infections, false aneurysms or aorto-duodenal fistulas

tured group, 15% in the urgent group, and 19% in the elective group.

Aneurysm size as measured on ultrasound varied from 3.5-12cm in diameter in the elective and urgent groups (average 6.5cm) and 5-11cm (average 8.5cm) in the ruptured group. Blood replacement averaged 2.75 units in the elective and urgent group and nine units in the ruptured group. The usual location of the rupture was into the retroperitoneal space; there were two ruptures into the vena cava. Both of these patients survived. There were 80 males and 20 females. Interestingly, of a total of 13 comprising the urgent group, seven were females. Average age of the elective and urgent group was 69 years, and 70 years in the ruptured group.

Patients operated electively were evaluated with ultrasound and intravenous pyelography. Arteriography was not employed routinely, but evidence of additional peripheral vascular disease was one indication for this test. There were no cases of severe renal artery stenosis with hypertension. The graft inclusion technique was used in every case and all grafts were knitted Dacron®, 16-22mm in diameter. Straight tube grafts were employed in 32% of the non-ruptured group, and in 21% of the ruptured group. Twelve iliac aneurysms were treated, nine in the elective group and three in the ruptured group. There were no ruptured iliac aneurysms, but two were symptomatic.

Discussion

Abdominal aortic aneurysm continues to be a prevalent vascular degenerative disease. Late diagnosis with rupture and an unacceptably high mortality is demonstrated in both this series of 100 cases and in others. A 28% incidence of rupture is high compared with a larger series reviewing the years 1974-1982, when the incidence was only 13%.[1] The 59 cases operated electively all survived surgery. This supports the policy of careful examination of patients for aneurysm in order to permit elective rather than urgent or emergency operation. It is important to note that the majority of patients with ruptured aneurysm in this series had no knowledge of the aneurysm prior to its sudden rupture. In addition, some of the ruptured aneurysms were probably undetectable on physical examination prior to rupture because of small size and/or patient obesity.

The surgical mortality in this small series compares favorably with the 860 cases reported by Crawford.[4] Elective surgical mortality was 4.76%, with a mortality of only 1.43% in the most recent review. In an attempt to reduce intraoperative blood loss, we are now using woven Dacron® grafts exclusively. But, the very high operative mortality with ruptured aneurysm continues to be a problem in this and other series, despite aggressive use of the Swan-Ganz catheter, prolonged mechanical ventilation, and rapid volume replacement.

We use CT scan as the usual imaging technique preoperatively, and ultrasound is employed for serial evaluation of aneurysm size. The arteriogram continues to be used in selected cases.

Summary

One hundred surgical cases of abdominal aortic aneurysm were reviewed. There were no deaths in the 59 patients operated electively, two deaths (15%) in the 13 cases operated urgently, and 11 deaths (39%) in the 28 cases operated after rupture. Abdominal aortic aneurysm can be operated with an

acceptable mortality in the community setting. Delay in diagnosis continues to be the major problem in treating this disease.

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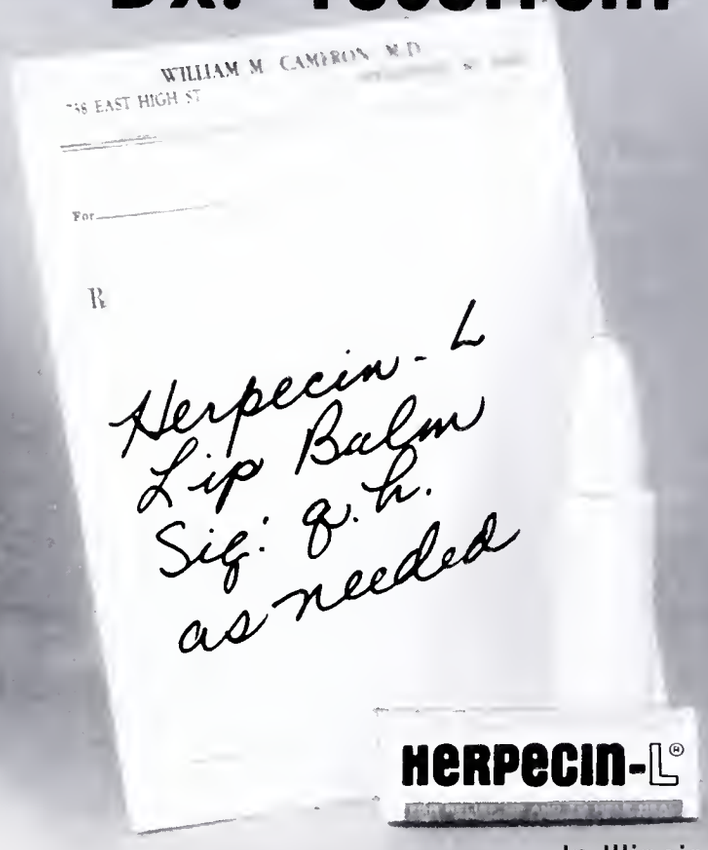
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The Effects of Celestial Events on Births in Champaign-Urbana

Moonlight and Champaign

By Roger P. Smith, M.D. and Diane Essex-Sorlie, Ph.D./Urbana

Past evaluations of the effect of lunar phase on birth rate found either no effect or inconsistent, weak effects. A total of 14,427 births occurring over a period of 5,910 days ending November 11, 1981 were reviewed. This time period encompassed 200 lunar phase cycles and 216 lunar orbits. No clinically meaningful variations in birth rate were found with either cycle, though statistical analysis did reveal an asymmetric sine-like wave when half-cycle moving averages were compared.

It is a commonly held belief that the frequency of birth is related to, or even determined by, the phases of the moon. When this hypothesis has been subjected to scientific study, inconsistent or conflicting findings have been the result. From studies done in 1938, Gunther concluded that more births occurred seven to nine days after a new or full moon.[1] In 1949, Schnurman reported that an increased number of births occurred within 24 hours of the full moon in 66.7% of the 40 months he studied (2,691 births).[2] Hosemann, in 1950, published involved accounts supported by tables and diagrams, indicating no connection between phases of the moon and daily birth rates.[3,4] In 1957, Rippmann reported no demonstrable lunar effect on 9,551 births over 10 years' time.[5] In 1954 and again in 1967, Menaker reported weak associations between the number of live births and the lunar cycle, based on 112 and 37 lunar cycles, respectively.[6,7] His findings, however, were not consistent. In the first study, Menaker indicated the highest rate of deliveries occurred +/−3 days from the time of the full moon. In the second study, he found the highest rate was distributed broadly over the half cycle from first quarter +1 day to last quarter. Further, Osley reported a maximum number of births before a full moon and a minimum immediately following.[8] Fifty one cycles and 11,691 births were examined by Abell in 1979.[9] But Abell and his colleagues were unable to demonstrate any correlation with lunar phase. Most recently, Witter[10] reported no significant trends in an analysis of 12 lunar months involving a total of 2,697 deliveries, though some questions regarding the validity of his attempts to fit linear and polynomial curves to the data might be raised.

The weakness of the effects seen has been rationalized by the fact that studies which have found lunar influence have all been done in metropolitan centers where the effects of the moon's phase on day-to-day life may be less. It has even been proposed that "... greater lunar effects may be present in cultures without electricity, where the moon provides the principal nighttime illumination and permits social mobility."[8] While Champaign-Urbana, Illinois, has enjoyed the benefits of electricity for many years, the lack of bright lights and the presence of (relatively) clean air make it possible for the general population to observe the phases of the moon. To assess what effects this may have, the following study was undertaken.

Materials and Methods

The delivery records of our institution were searched beginning

The most ingenious way of becoming foolish, is by a system.

—Anthony Ashley Cooper, Third Earl of Shaftesbury, 1671—1700

November 11, 1981 (full moon) backwards for 5,910 days to September 9, 1965. This represented just over 200 lunar phase cycles and slightly more than 216 lunar orbits. The number of deliveries occurring on each calendar day was recorded without regard to fetal outcome or mode of delivery. Elective deliveries, including cesarean sections, were not eliminated despite the potential difficulty of accurate identification being close to the natural time of delivery. Any biases, such as day of the week, would be statistically eliminated by the number of cycles studied. Premature deliveries were also not identified or eliminated.

After the number of deliveries was compiled, the total for each day was entered into a micro-computer and stored. The computer was then programmed to compile the total and average number of deliveries which occurred during each portion of the cycle being evaluated. Because none of the cycles studied corresponded to a whole (integer multiple) number of days, the use of some assumptions was necessary to avoid progressive errors with each cycle. Number of deliveries were assigned to the nearest hundredth (1%) of a cycle based on the fractional result of the division of the day number by the cycle length (*e.g.*, day 378/29.531 days per cycle = 12.80 cycles, or .80 cycle fraction). This process was repeated for each cycle studied. For the lunar cycles, the values for each of these cycle fractions represented data compiled from between 57 and 61 actual days. Thus, of the 5,910 days, between 57 and 61 days fell on each one percent of the cycle. By constructing frequency distributions in this manner, it is possible to eliminate the effects of non-integer cycles over a long period of time, removing one source of possible error present in the previous studies.

For each cycle fraction, the mean number of deliveries, standard deviation, and standard error of the mean were calculated. Moving averages were computed for the quarter cycle before and after each cycle fraction. The resulting moving averages were then subjected to linear and polynomial regression analyses.

In addition to the orbits and phases described previously, the day of the week and yearly distribution were determined, as well as the distribution, average, and standard deviation of all deliveries. A total of 14,427 deliveries was reviewed.

Results

During the time period studied, 14,427 deliveries were evaluated. The average (mean) number of deliveries per day was 2.44, with a standard deviation of 1.61. The distribution of daily deliveries varied from zero (on 584 days) to 11 (one day) with a mode of two (1,518 days). The total number of deliveries by year varied from a low of 805 (1976) to 1,040 (1981). The annual distribution is shown in Figure 1.

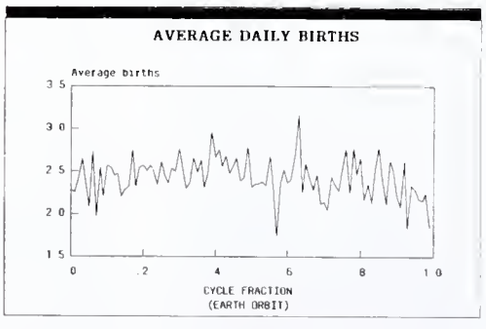


Figure 1
The distribution of births occurring over the year is shown for 15 complete January to January cycles. The average of these averages is 2.42 with a standard deviation of 0.232.

The distribution of deliveries by day of the week is shown in Figure 2. The maximum number of deliveries by day occurred on Wednesday, which is consistent with the findings of other authors.[11] This maximum was not statistically significant from other days of the week. The mean number of births occurring during the lunar phase cycle is shown in Figure 3. The number of days compiled for each cycle fraction (1% of cycle) varied from 57 to 61 depending on the cycle length and number of complete cycles covered by the data (843 days compiled for each day in the day of the week analysis). Contained in Figure 4 is the graph of the actual average number of deliveries by moving half cycle fraction and the fitted polynomial (cubic) regression function for the phase data.

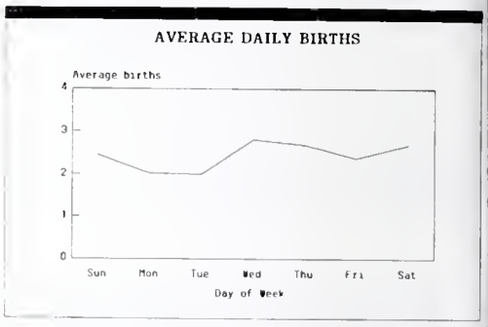
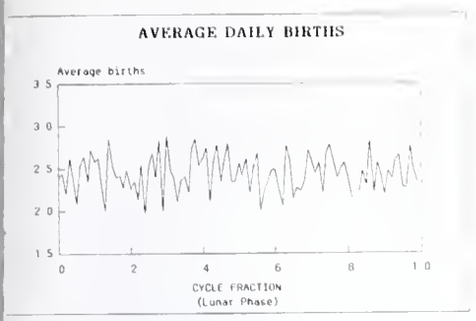


Figure 2
The average number of deliveries by day of the week is plotted beginning with Sunday (day 1). This data is based on 843 complete weekly cycles. The standard deviation for points shown varies from 1.47 (Monday) to 1.68 (Thursday).

Linear, quadratic, cubic, and quartic models were fitted to the data and examined for adequacy of fit. The cubic model (sine wave) provided the best fit or description of the data ($R = 0.66$, $R^2 = 0.44$, $P < .0001$). This finding is consistent with the hypothesized relationship, as well as the findings of other authors.[8,10]

Results similar to those described above were obtained when the phase data were analyzed. Overall, the cubic function provided the



igure 3
he average number of births for each % of the lunar phase cycle are hown. Cycle fraction was assigned by ividing the day number by the cycle ength and assigning that day's deliv- eries to the closest hundredth of a ycle. The origin represents the orbital osition of the moon corresponding with that of the full moon on Novem- ber 11, 1981. The cycle progresses backward to the same place in the orbit one cycle earlier at 1.00. Full moon occurs at 0.00 on this graph and the cycle progresses backward with first quarter at 0.25, new moon at 0.50, and last quarter at 0.75. A total of 200 cycles was compiled.

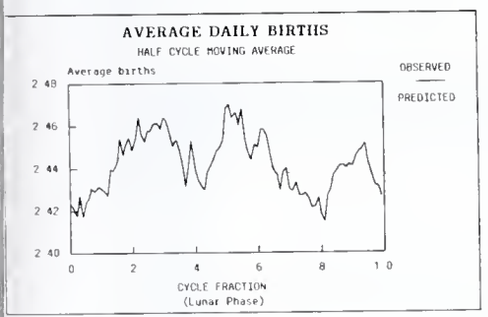


Figure 4
The half-cycle moving average for average number of deliveries by cycle fraction and the regression function derived from polynomial regression analysis is shown for the lunar phase.

best statistical description of the relationship between the average number of deliveries and lunar phase ($R = 0.67$, $R^2 = 0.46$, $P < 0.001$).

Discussion

Inspection of the data contained in Figure 1 shows that there are no apparent trends in the distribution of deliveries over the course of the year. This was somewhat unexpected because of the population shifts which occur in a university center. There appears to be a slight decline in births during January, though this variation was not statistically significant.

When the distribution of births over the lunar orbit and phase is examined (Figure 3), no broad trend is obvious. There is the suggestion of a wave-like pattern, though this is heavily obscured by the background variation present. It is only when moving average data are obtained that this pattern appears to emerge (Figure 4). When regression analysis was done, it was found that a cubic (sine-wave) function provided the most satisfactory statistical description of the data. Despite the finding that a cubic function best describes the variations found in the half-cycle moving average data to a level of confidence that vastly exceeds chance ($p < 0.0001$), this does not automatically validate the hypothesis that lunar orbit and phase affect the rate of deliveries.

It seems apparent that if we search for a force acting on the rate of deliveries that is related to the orbit or phase of the moon, several characteristics of that force (and the resultant rate of deliveries) can be deduced intuitively. Because of the periodicity of the moon's orbit and phase, the force must also exhibit cyclic periodicity. Similarly, the effects of the force should be sinusoidal and symmetric. That is, the point of maximum effect should be approximately one-half cycle removed from the point of minimum effect. Further, the graph of the hypothesized effect should "wrap around" or start and stop at similar Y-axis values, allowing any graph of one cycle to be joined to itself edge to edge to form a cylinder. The sine function, taken over one full wave, is an example of such symmetry. Only data from the lunar phases seem to approach any of these proposed characteristics, but the fit appears to be less than ideal and symmetry has not been achieved.

The apparent discrepancy between the statistical ability to fit a curve to the data and the failure of that curve to fit the intuitive or anticipated characteristics of a lunar force may be explained in part by the nature of the statistics themselves. One consequence of using a wide-moving average along with the large number of deliveries and cycles compiled is that an extremely high degree of statistical power is associated with the results. A high degree of power allows statistical significance to be achieved, and permits conclusions about associations between number of deliveries and lunar phase or orbit, even in the face of relatively large variability in the original data. (It is this degree of power which is needed to eliminate such potentially confounding factors as cesarean and premature births.) A high degree of power (or the lack of it) may even account for the failure of some authors to observe significant relationships.[3,4,11]

Another problem that has lead to conflicting observations in the past is that most researchers have failed to correct for the fact that neither lunar orbit nor phase cycles represent an even (integer) number of days. This failure has meant that there is a progressive error equivalent to the difference between the assumed cycle length and the true cycle length (*i.e.*, 29 days—29.531 days for lunar phase). For example, in the case of lunar phase, an error of more than one day for each two cycles would result and would further complicate or invalidate any conclusions drawn. The use of cycle fractions eliminates this problem, but makes clinical application of findings somewhat more difficult. In the current study no attempt was made to assess time of day or the actual celestial location of the moon at the time of the delivery in an effort to assign cycle fraction. With the statistical power provided by the large number of cycles and observations, this was unnecessary. The application of the resultant findings, especially the half-cycle moving averages, is difficult; individual cycle fractions represent less than one third of a 24 hour day. Half-cycle moving averages represent more than two weeks of time. Thus, even if an ideal sinusoidal, symmetric, statistically significant relationship between lunar phase or cycle was found, it is unlikely that it would be clinically noticeable without a large amplitude variation. The cubic curve best fitted to the data

from lunar phase shows only a 0.025 delivery per day variation from maximum to minimum.

It is apparent that for data with the best statistical evidence of effect (lunar phase), the observed effect is small, with a maximum delivery rate occurring around cycle fraction 0.3 and a minimum near 0.8. The predicted spread between these points is approximately 0.025 deliveries per day, compared to an average of 2.44, or roughly one per cent variation. This degree of variation represents little clinical significance when compared to an overall standard deviation of 1.61 deliveries per day and a range of 0 to 11.

While it is possible through statistical manipulations to demonstrate significant correlations between half-cycle moving averages of birth during lunar cycles and a cubic function (sine-like wave), this statistical relationship does not prove the assertion of cause and effect and should have no demonstrable clinical effect on the day-to-day delivery of health care, or on the likelihood of a given woman delivering at a particular time of the lunar month. ◀

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Springfield Memo

(continued from page 124)

- *Donald L. Griffin* (lic. # 036-039250)
 Effective May 16, 1988, Dr. Griffin's medical license was placed on probation.
- *Patricia Jones* (lic. # 036-073713)
 Effective April 19, 1988, Dr. Jones' medical license was placed on probation for 2 years, and she was fined.
- *Shahnaz Khan* (lic. # 036-063804)
 Effective May 12, 1988, Dr. Khan's medical license was suspended indefinitely.
- *Keith Meredith King* (lic. # 036-045762)
 Effective May 12, 1988, Dr. King's medical license was suspended indefinitely.
- *Bernard Lerner* (lic. # 036-047332 & 003-036-047332)
 Effective January 3, 1988, Dr. Lerner's medical and controlled substance licenses were revoked.
- *Federico R. Macaraeg* (lic. # 036-051165 & 003-036-051165)
 Effective May 16, 1988, Dr. Macaraeg's medical license was placed on probation and his controlled substance license was suspended.
- *Ferdinand J. Marzinelli* (lic. # 036-027191 & 003-036-027191)
 Effective June 1, 1988, Dr. Marzinelli's medical license was suspended indefinitely and his controlled substance license was revoked.
- *William Monroe Orr* (lic. # 036-063668)
 Effective March 25, 1988, Dr. Orr's medical license was suspended indefinitely.
- *James E. Pero* (temp. lic # 125-018303)
 Effective April 19, 1988, Dr. Pero's temporary license was placed on a 2 year probation and he was fined.
- *Barry R. Pesetsky* (lic. # 036-043206)
 Effective May 12, 1988, Dr. Pesetsky's medical license was suspended indefinitely.
- *Gary M. Reagan* (lic. # 036-064567)
 Effective March 28, 1988, Dr. Reagan's medical license was placed on probation with certain conditions.
- *Ray Roya* (lic. # 036-033415)
 Effective June 1, 1988, Dr. Roya's medical license was indefinitely suspended.
- *Gustave B. Schmidt* (lic. # 036-019858 & 003-036-019858)
 Effective June 20, 1988, Dr. Schmidt's controlled substance license was placed on a one-year probation.
- *Kishor Hansraj Shah* (lic. # 036-061631)
 Effective May 16, 1988, Dr. Shah's request for restoration of his medical license was denied and it remains suspended.
- *Barry G. Siegal* (lic. # 036-057914)
 Effective April 12, 1988, Dr. Siegal's medical license was suspended, but the suspension was stayed, and the license placed on probation for an indefinite period, with certain conditions.
- *Frederick Snyder* (lic. # 036-034323)
 Effective May 12, 1988, Dr. Snyder's medical license was suspended indefinitely.
- *Sheila W. Sorkin* (lic. # 036-043450)
 Effective March 25, 1988, Dr. Sorkin's medical license was placed on probation for 3 years.
- *Ceilla M. Stanzel* (lic. # 036-059999)
 Effective May 12, 1988, Dr. Stanzel's medical license was suspended indefinitely.
- *Chi Feng Su* (lic. # 035-049693 & 003-036-049693)
 Effective June 15, 1988, Dr. Su's medical and controlled substance licenses were indefinitely suspended.
- *Shanmugha K. Sundaram* (lic. # 036-044833)
 Effective May 5, 1988, Dr. Sundaram's medical license was reprimanded.
- *Luke Y.S. Tan* (lic. # 036-050657)
 Effective May 16, 1988, Dr. Tan's medical license was suspended indefinitely.
- *Edward Tapper* (lic. # 036-052335)
 Effective May 16, 1988, Dr. Tapper's medical license was placed on probation.
- *James R. Tosetti* (lic. # 036-037134)
 Effective March 25, 1988, Dr. Tosetti's medical license was surrendered indefinitely.
- *Paulette Trumm* (lic. # 036-072698)
 Effective March 25, 1988, Dr. Trumm's medical license was restored to good standing.
- *Lee Allen Woolf* (lic. # 036-039386)
 Effective May 12, 1988, Dr. Woolf's medical license was suspended indefinitely.
- *Philip Scott Zimmerman* (lic. # 036-059066 & 003-036-059066)
 Effective May 11, 1988, Dr. Zimmerman's medical license was reinstated and placed on an indefinite probationary period, under certain conditions. ◀

Quit Smoking Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state.

The Council is able to provide information about training programs for clinic moderators, for-credit training programs for nurses planning to moderate "I Quit" clinics and regular industrial programs.

Inquiries should be addressed to the Council at 1440 W. Washington Blvd., Chicago 60607. Telephone (312) 243-2000.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

In addition, the American Cancer Society provides Fresh Start clinic training anywhere in Illinois for hospitals and industries. Educational materials, pamphlets, posters, films and training can also be obtained at no charge. For information, contact your local ACS office, or the Illinois Division, Inc., at 37 South Wabash Ave., Chicago 60603; (312) 372-0471.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

October 4	Rush North Shore Medical Center	*Skokie*
October 17	Weiss Memorial Hospital	*Chicago*
October 31	Little Company of Mary Hospital	*Evergreen Park*
To Be Announced		
	Ambutal	*Crystal Lake*
	Christ Hospital	*Oak Lawn*
	Copley Memorial Hospital	*Aurora*
	Delnor Community Hospital	*Geneva*
	Dreyer Clinic	*Aurora*
	Field Medical Group	*Chicago*
	Highland Park Hospital	*Highland Park*
	Hinsdale Hospital	*Hinsdale*
	Memorial Hospital for McHenry Cty	*Woodstock*
	Mendota Community Hospital	*Mendota*
	Northern Il. Med. Ctr.	*McHenry*
	Olympia Fields Osteo. Med. Ctr.	*Olympia Fields*
	Ravenswood Health Care Ctr.	*Chicago*
	Resurrection Hospital	*Chicago*
	Sherman Hospital	*Elgin*
	South Suburban Hospital	*Hazel Crest*
	West Town Public Health Ctr.	*Chicago*

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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(continued from page 122)

Diagnosis: Juvenile Laryngeal Papillomatosis

Many diseases cause multiple cavitary lung lesions (Table 1), but only a few are associated with the combination of cavitary lung lesions and airway abnormalities. All of the choices given can produce this combination. Wegener's granulomatosis commonly causes cavitary lung lesions and occasionally causes tracheal and bronchial lesions. Amyloidosis can produce lung nodules which cavitate and can also involve the trachea and bronchi. Relapsing polychondritis often affects the trachea and bronchi. Secondary pneumonia is common in this disease but without cavitary nodules. These three diseases are rare in children. Laryngeal papillomatosis, however, is usually found in children and can spread to the trachea and peripheral airways, producing cavitary lesions.

Table 1*
Multiple Cystic Lung Lesions

Congenital, Neonatal
Bronchopulmonary dysplasia
Wilson-Mikity syndrome
Cystic adanomatoid malformation
Airway Diseases
Bullous emphysema
Cystic bronchiectasis
Infectious Diseases
Tuberculosis
Atypical tuberculosis
Staphylococcal pneumonia
Gram-negative pneumonia
Melioidosis
Parasitic disease; echinococosis, paragonimiasis
Embolic Disease
Pulmonary thromboembolism with cavitation
Septic emboli
Neoplastic Disease
Hematogenous metastases
Alveolar cell carcinoma
Pulmonary spread of laryngeal papillomatosis
Lymphoma
Collagen Vascular Disease
Rheumatoid lung
Wegener's granulomatosis
Idiopathic Disease
Sarcoidosis
Histiocytosis X
Amyloidosis
Trauma
Hydrocarbon ingestion with pneumatocele formation
Traumatic lung lacerations
Pneumoconiosis
Progressive massive fibrosis

**Modified from* Godwin, J.D., Webb, W.R., Savoca, C.J., Gamsu, G., Goodman, P.C.: "Multiple Thin-Walled Cystic Lesions of the Lung," *AJR* 135:593-604, 1980.

Juvenile Laryngeal Papillomatosis

Laryngeal papillomas are the most common benign neoplasms of the larynx in children. With the existence of multiple lesions, this condition is called juvenile laryngeal papillomatosis (JLP), although laryngeal papillomatosis has been known to present in middle-aged to elderly adults. The course of JLP is variable. Many cases resolve spontaneously, but lesions tend to recur after excision.[1]

Although classified as benign, JLP may behave aggressively by extension of papillomas into the tracheobronchial tree, lung parenchyma, and occasionally, into the soft tissues of the neck. This aggressive form of JLP has been termed invasive papillomatosis. Some cases have demonstrated cytologic atypia, suggesting conversion of papillomatosis to well-differentiated squamous carcinoma.[1,2] Most cases of squamous carcinoma in JLP have followed radiation therapy or occurred in older adults. Distant metastases generally do not occur. Host immune defects, cocarcinogens, and long term viral exposure are implicated in malignant conversion.[3]

Pathology

Papillomas may appear cauliflower-like, pedunculated or sessile.[4] The usual histopathology is papillary formation with irregular folds of well-differentiated stratified squamous epithelium on a fibrovascular core with a well-defined basement membrane.[5] Convincing evidence links JLP with Human Papilloma Virus (HPV): types of HPV found in genital condylomata are the same as HPV found in JLP.[3] The high prevalence of genital condylomata in mothers of children with JLP suggests that infection occurs in the birth canal and laryngeal papillomas then develop after years of latency.[6]

Approximately 2% of patients with JLP develop distal spread, usually only to the trachea. Distal spread tends to follow a pattern: laryngeal papillomas are usually discovered before age five, and the patient usually has a history of multiple endoscopic procedures or tracheostomy. The interval between initial laryngeal involvement and the discovery of bronchoalveolar papillomatosis averages 12 years.[7]

The mechanism of extension beyond the larynx is not clear but seems to be connected to intervention. Mechanical trauma in the form of treatment of lesions or tracheostomy appears to induce the spread of papiilomas to the distal respiratory tree.[7]

Clinical

The most common presenting symptom is voice change, usually moderately severe and progressive. In some cases there is aphonia.[5] Dyspnea due to airway obstruction is common and stridor is present in one-third of patients. Many of these patients receive misdirected treatment prior to the diagnosis of JLP. A child may initially be considered to have vocal cord nodules, vocal cord paralysis, asthma, allergic croup, tracheoesophageal fistula, obstructing tonsils, or laryngomalacia.[5]

About two-thirds of affected children show symptoms of papillomatosis prior to four years of age. The disease can recur after years of quiescence. Recurrences are more prevalent in children in whom laryngeal papillomas are multiple and have deeper attachments.[7]

Radiology

Parenchymal lung findings are present following distal spread of papillomas. A tracheostomy tube is almost always present. Occasionally, a radiologic exam shows enlargement and deformity of the glottis by irregular nodular masses.[6] Tracheal and bronchial walls may be irregular or narrowed.[2] The parenchymal findings may resemble those of saccular or cylindrical bronchiectasis. Parenchymal lung lesions include thin-walled cysts, nodules, patchy densities, and fibrosis. The cysts may contain air-fluid levels.[2] The frequent right upper lobe location of early lesions supports the concept of transbronchial spread due to aspiration.[8]

Treatment and Prognosis

Establishment of an airway is a priority in treatment. This can be accomplished by repeated endoscopic procedures rather than tracheostomy.[5] A variety of techniques have been used with the aim of minimizing tissue damage and spread distal to the larynx. Unfortunately the tumors may recur relentlessly, necessitating multiple operations and tracheostomy. Recently the frequency of tracheostomy has been reduced with the use of laser for removal.[6]

Although a myriad of treatments have been used over the years, children and adults with papillomas may continue to experience hoarseness, airway obstruction and tracheopulmonary invasion, despite frequent operative procedures. Interferon treatment has produced tumor regression, but regrowth of the papillomas after the completion of treatment has been seen.[9] Clinical improvement in one patient with pulmonary spread of JLP after administration of transfer factor has been reported.[6] ◀

References

1. Fechner, R.E., Goepfert, H., Alford, B.R.: "Invasive Laryngeal Papillomatosis," *Arch Otolaryngol* 99:147-151, 1974.
2. Godwin, J.D., Webb, W.R., Savoca, C.J., Gamsu, G., Goodman, P.C.: "Multiple Thin-Walled Cystic Lesions of the Lung." *AJR* 135:593-604, 1980.
3. Schnadig, V.J., Clark, W.D., Clegg, T.J., Yao, C.S.: "Invasive Papillomatosis and Squamous Carcinoma Complicating Juvenile Laryngeal Papillomatosis," *Arch Otolaryngol* 112:966-971, 1986.
4. Silverman, F.N. (ed.): Caffey's Pediatric X-Ray Diagnosis. Chicago, Year Book Publishers, 1985, pp 1275.
5. When, S.R., Seltzer, S., Geller, K.A., Thompson, J.W.: "Papilloma of the Larynx and Tracheobronchial Tree in Children," *Ann Otol* 89:497-503, 1980.
6. Borkowsky, W., Martin, D., Lawrence, H.S.: "Juvenile Laryngeal Papillomatosis with Pulmonary Spread," *AJDC* 138:667-669, 1984.
7. Singer, D.B., Greenberg, S.D., Harrison, G.M.: "Papillomatosis of the Lung," *Pediatr Radiol* 94:777-781, 1966.
8. Kirks, D.R.: Practical Pediatric Imaging. Boston/Toronto, Little, Brown and Co., 1984, pp 432-438.
9. McCabe, B.F., Clark, K.F.: "Interferon and Laryngeal Papillomatosis," *Ann Otol Rhinol Laryngol* 92:2-7, 1983.

ISMS Physician Help Line

Are you troubled by chemical dependency, alcoholism, physical or mental problems, or concerned about someone who has an impairment? Are you having emotional or physical problems dealing with your involvement in a malpractice suit?

If so, contact the PHYSICIAN HELP LINE, 312/580-2499, a confidential, advocacy service offered by the ISMS Physician Assistance Program and the Physician Support Group to link troubled physicians and their families with resources to help them.

The Physician Help Line calls will be answered, as soon as possible, by Dr. Violet M. Eggert, Medical Director of the Physician Assistance Program.

A Look at Auxiliary Benefits

By Laura Hays (Mrs. Philip),
First Vice-President and Membership Chairman

President Sherry Betsill's theme for 1988-89 is "Auxiliary: The Focus Is On You." The Illinois State Medical Society Auxiliary is an active, worthwhile organization with a definite focus on the needs of its members. It provides an outlet for learning, earning, caring and sharing through monthly meeting programs, a tradition of support for AMA-ERF, local community health projects and a common meeting ground for physician spouses.

A recent national news magazine featured an article on the declining membership of women's organizations. (The ISMSA is not truly a "women's" organization as it welcomes the membership of male spouses, but a look at our roster shows it to be overwhelmingly female.) The article indicated that most women's clubs are struggling to keep members since women now have a wider choice of career and other outlets. It suggested that those clubs with the most chance for success are those that offer flexible scheduling and give their members a feeling that they are doing something worthwhile.

The ISMSA fits this description but is unique, in that our organization is directly linked to our spouses' livelihood, freedom, happiness and fulfillment. Auxiliary participation is not an extra-curricular, outside-of-the-family involvement. Rather, it works to improve the strength and well-being of every member's marriage, family and quality of life. Few outlets for women can claim this.

As the ISMSA "focuses" on its members' needs this year, it "pictures" every physician spouse in Illinois as an Auxiliary member. Exciting things can certainly "develop." Join us!

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November 14-16, 1988
Sports Medicine for the Primary Care Physician
November 16-18, 1988
Specialty Review in Thoracic Surgery
January 9-14, 1989
Review Course in Neurological Surgery
February 3-12, 1989
The Biologic Basis of Neurology and Psychiatry: A Review for Board Candidates and Established Practitioners
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Specialty Review in General Surgery, Part II
February 20-March 3, 1989
The Clinical Basis of Psychiatry: A Comprehensive Review and Update
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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

October

Cardiology

Balloon Application in Cardiovascular Medicine
For: Cardiologists, Internists, Family Practitioners, Physicians-in-Training and Nurses. October 29, Peoria, Illinois. **Sponsor:** The Methodist Medical Center of Illinois, 221 N.E. Glen Oak Avenue, Peoria, IL 61636. **Fee:** $40. **Reg. Limit:** None. **Credit:** Category 1: 5 hours; AAFP Prescribed: TBD. **Contact:** Jerelyn Blackburn. **Phone:** (309) 672-4895.

Cardiology, Orthopedics, Sports Medicine

Symposium on Cardiac Rehabilitation and Orthopaedic and Sports Injuries
For: MDs, RNs, PTs, OTs. Workshop and symposium: October 18-21, La Crosse, WI. **Sponsors:** La Crosse Exercise and Health Program and the Wisconsin Heart Institute, 221 Mitchell Hall, University of Wisconsin-La Crosse, La Crosse, WI 54601. **Fee:** before September 6: $275 for workshop and symposium; $225 for symposium only; after September 6: $350 for workshop and symposium; $275 for symposium only. **Reg. Limit:** workshop: 25; symposium: none. **Credit:** Category 1: workshop—8 hours; symposium—20 hours. **Contact:** Patricia L. Hutchinson. **Phone:** (608) 785-8686.

Dermatology

Day of Learning: "Skin Signs of Systemic Disease" and "Newer Aspects of Contact Dermatitis"
For: Dermatologists. Lectures: October 5, Evanston, IL. **Sponsor:** Great Lakes Dermatological Society, 2324 W. Peterson Avenue, Chicago, IL 60659. **Fee:** $60 for practicing physicians; $20 for residents. **Reg. Limit:** 100. **Credit:** Category 1: 6 hours. **Contact:** Silas Wallk, M.D. **Phone:** (312) 973-2666.

Emergency Medicine

For: Emergency physicians. Course: October 14-19, Chicago, IL. **Sponsor:** Illinois Chapter of the American College of Emergency Physicians, 1545 Des Plaines Avenue, Suite 16, Des Plaines, IL 60018. **Credit:** Category 1: 56 hours. **Contact:** Jeannine Helms. **Phone:** (312) 298-1970.

Internal Medicine

Specialty Review in Nephrology
For: Nephrologists and internists. Lecture: October 10-14, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 521-4651 (outside Illinois).

Lowering Your Patients' Cholesterol: A Symposium for Physicians
For: All physicians. **Symposium:** October 5, Carbondale, IL. **Sponsor:** Southern Illinois University School of Medicine, Carbondale, IL 62901. **Fee:** TBA **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Hurley Myers, Ph.D. **Phone:** (618) 536-5513.

Specialty Review in Rheumatology
For: Rheumatologists and internists. Lecture: October 3-7, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $645. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Neurology

Current Clinical Neurology: A Comprehensive Review
For: Neurologists, psychiatrists, and neurosurgeons. Lecture: October 24-28, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $570. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Nuclear Medicine, Radiology

Forecast for the 1990's—Practical Advances in Nuclear Medicine
For: Physicians and technologists. Seminar: October 15-16, 1988, Rosemont, IL. **Sponsor:** Society of Nuclear Medicine, Central Chapter, 2321 Fourth Street, Suite 111, Tucker, GA 30084. **Fee:** nonmember MD: $110, nonmember technologists: $75; residents and technology students: $30; discount for Central Chapter members. **Reg. Limit:** none. **Credit:** Category 1: 10.4 hours. **Contact:** Dennis Park. **Phone:** (404) 493-4524.

Obstetrics and Gynecology

Specialty Review in Obstetrics and Gynecology: Practical Aspects
For: Obstetricians and gynecologists. Lecture: October 16-22, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $715. **Credit:** Category 1: 55 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Pathology

Advances in Anatomic and Clinical Pathology
For: Pathologists. Lecture: October 16-21, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $630. **Credit:** Category 1: 51 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Pediatrics, Family Practice

Seminar in Pediatrics
For: Physicians and other interested health professionals. Conference: October 28-29, Madison, WI. **Sponsor:** University of Wisconsin, Continuing Medical Education and Dept. of Pediatrics, University of Wisconsin School of Medicine, 2715 Marshall Court, Madison, WI 53705. **Fee:** TBA **Credit:** Category 1: 10 hours; AAFP: 10 hours pending; AOA Category 2-D: 10 hours. **Contact:** Cathy Means, Program Coordinator. **Phone:** (608) 263-6637.

Psychiatry

Multiple Personality/Dissociative States
For: Psychiatrists, nurses, social workers. Lecture/workshop: October 6-9, Chicago, IL. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, Office of Continuing Education, 600 S. Paulina, Chicago, IL 60612. **Fee:** $245. **Credit:** Category 1: 25 hours; APA: 24 hours. **Contact:** Continuing Medical Education. **Phone:** (312) 942-7095.

Pulmonary Diseases

Second Annual Weekend Refresher in Pulmonary Diseases
For: Primary Care Physicians. Practical review with lectures and case oriented discussions, October 14-15, Galena, IL. **Sponsor:** The University of Illinois College of Medicine at Chicago, Dept. of Medicine, Section of Respiratory and Critical Care Medicine, 912 S. Wood Street, (m/c 607), Chicago, IL 60612. **Fee:** $195. **Reg. Limit:** 120. **Credit:** Category 1: 10 hours applied for; AAFP Prescribed: 10 hours applied for. **Contact:** Sue Talbert. **Phone:** (312) 996-4631.

Surgery

Specialty Review in General Surgery, Part II
For: General and specializing surgeons. Lecture: October 3-14, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $880. **Credit:** Category 1: 103 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

November

General Practice, Internal Medicine

Coronary Heart Disease: Current Concepts
For: General practitioners, internists. Lecture/workshop:

November 11-12, Chicago, IL. **Sponsor:** Medical Education Resources, 5808 South Rapp Street, Suite 202, Littleton, CO 80120. **Fee:** $295. **Reg. Limit:** 40. **Credit:** Category 1: 11 hours; AAFP prescribed: 11 hours. **Contact:** Deborah Wilderson. **Phone:** (800) 421-3756 (outside Colorado); (303) 798-9682 (in Colorado).

Hematology/Oncology

Antidote to Adjuvant—The Changing Role of Leucovorin in Clinical Oncology
For: Hematologists and oncologists. Symposium: November 9, Chicago, IL. **Sponsor:** The University of Chicago School of Medicine, Center for Continuing Medical Education, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 3 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Infectious Diseases

3rd Annual Conference on Concepts and Controversies in Infectious Diseases
For: Pharmacists, physicians and microbiologists involved in treatment of infectious diseases. Conference: November 18, Chicago, IL. **Sponsor:** The University of Illinois College of Pharmacy (Dept. of Pharmacy Practice and Office of Continuing Education) and College of Medicine (Section of Infectious Diseases), c/o Conferences and Institutes (m/c 607), 912 S. Wood, Chicago, IL 60612. **Fee:** $35. **Credit:** Category 1: 5 hours. **Contact:** Conference Registrar. **Phone:** (312) 996-5225.

Internal Medicine

Advances in Internal Medicine, 1988
For: Internists. Lecture: November 7-11, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $550. **Reg. Limit:** None. **Credit:** Category 1: 32 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Neurology

Neuroimmunology VI
For: Neurologists. Course: November 3-5, Chicago, IL. **Sponsor:** The University of Chicago School of Medicine, Center for Continuing Medical Education, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** 100. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Ophthalmology

Glaucoma Management for the 90's
For: Ophthalmologists. Conference: November 4-5, Chicago, IL. **Sponsor:** UIC College of Medicine, Dept. of Ophthalmology, 912 S. Wood Street, 2nd Floor North (m/c 607), Chicago, IL 60612. **Fee:** $250. **Reg. Limit:** 200. **Reg. Deadline:** October 21. **Credit:** Category 1: 10 hours. **Contact:** Sue Talbert. **Phone:** (312) 996-4631.

Laser for Common Fundus Diseases: A Workshop on the Why, When, and How of Treatment
For: Ophthalmologists. Workshop: November 18-19, Madison, WI. **Sponsor:** University of Wisconsin-Madison, Continuing Medical Education and Dept. of Ophthalmology, 2715 Marshall Court, Madison, WI 53705. **Fee:** TBA. **Reg. Limit:** 50. **Credit:** Category 1: 17 hours. **Contact:** Cathy Means, Program Coordinator. **Phone:** (608) 263-6637.

Phacoemulsification Workshop
For: Ophthalmologists. Lecture/wet lab: November 5, Chicago, IL. **Sponsor:** UIC College of Medicine, Dept. of Ophthalmology, 912 S. Wood Street, 2nd Floor North (m/c 607), Chicago, IL 60612. **Fee:** $100. **Reg. Limit:** lecture: none; wet lab: 50. **Reg. Deadline:** October 21. **Credit:** Category 1: 4 hours. **Contact:** Sue Talbert. **Phone:** (312) 996-4631.

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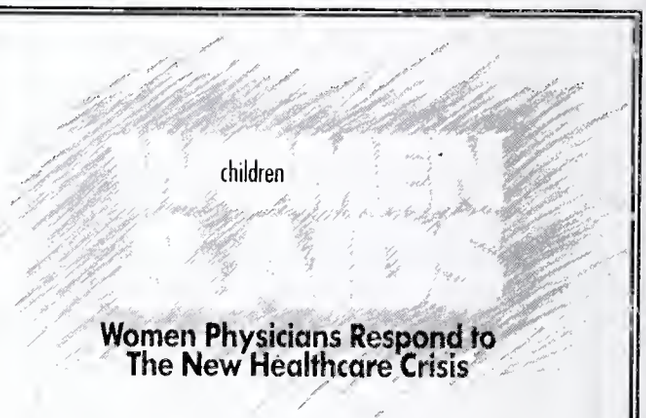
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BERNIE SIEGEL, M.D., AUTHOR, *Love, Medicine & Miracles*, will be the featured luncheon speaker, Thursday, October 13, 1988, 12:30-3:00 p.m., Chicago Hilton and Towers, Sponsored by the Ninth Forum for the Behavioral Sciences in Family Medicine, Hinsdale Hospital Family Practice Residency. Limited seating. Call (312) 887-2927, ask for Terri.

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Exchange Insights

September, 1988

ON MALPRACTICE PREVENTION

The Board of Governors of the Illinois State Medical Inter-Insurance Exchange presents "Exchange Insights on Malpractice Prevention" as a service to Illinois State Medical Society members and Exchange policyholders. This monthly feature is designed to educate physicians on those areas in their practice which have the potential for causing claims, and to offer possible ways to minimize risks. **Exchange Insights** *may be removed and kept with your other important Exchange professional liability information.*

The following article was written by David Ghitelman and originally appeared in the Nov. 9, 1987 issue of Medical Economics. *Copyright ©1987 and published by Medical Economics Company, Inc. at Oradell, New Jersey 07649. Reprinted with permission. Although it is not malpractice related, it provides important information about some of the legal issues surrounding AIDS.*

What Your Staff Must Know About AIDS

The inevitable finally happened, when the Centers for Disease Control reported that three health-care workers, in the course of their jobs, had become infected with the human immunodeficiency virus (HIV). More such cases have been reported since this initial occurrence in 1987. This chilling news may have frightened your staff into taking exaggerated precautions—or, at the other extreme, it may have done nothing to shake their belief that "none of our patients have AIDS, so we don't have to worry."

What's the proper response? According to the CDC, every doctor—whether or not he's ever seen an AIDS patient—should take measures now to protect himself and his staff against the possibility that someone infected with the virus will someday walk in the door. Since the AIDS virus can't be passed by casual contact but is transmitted through body fluids, any procedure that will expose you or your staff to these fluids calls for safeguards.

There's also a looming legal reason to be careful. The law is still unclear, but chances are that an infected office worker will be able to recover damages from her employer if she can show that he was negligent in protecting her from AIDS.

For now, the best protection for you and your staff is to follow the guidelines issued by the CDC for preventing HIV transmission in medical settings. Here are the ones that apply to doctors' offices:

- ☐ Wear gloves when any contact with blood or body fluids is likely, regardless of a patient's antibody status, and change the gloves after each patient encounter. If the procedure is likely to produce droplets of blood or body fluids, wear a mask and goggles. If splashes are likely, wear a gown or apron, too.
- ☐ Wash your hands immediately after any contact with blood or body fluids. Also wash your hands when removing gloves.
- ☐ Place used needles, scalpels, and other sharp objects in a puncture-proof container located as close as possible to the area of use. To avoid accidental sticks, do not recap, bend, or break needles or other sharp instruments. Place large-bore reusable needles in a puncture-resistant container for transport to reprocessing areas.
- ☐ Place blood samples in well-constructed containers with secure lids.
- ☐ Keep airways, resuscitation bags, and other ventilation devices available. The object, of course, is to avoid mouth-to-mouth contact with a patient.
- ☐ Avoid direct contact with patients and equipment used in their care if you have an exudative lesion or weeping dermatitis.

"You have to tailor the amount of caution you take to the specific job you're doing, rather than to the patient's diagnosis," observes Phyllis Spechko, a research nurse practitioner at the University of California San Diego Medical Center, which has been using precautions similar to the CDC guidelines for more than a year.

The trouble is, too many doctors and nurses still can't believe that a healthy-looking person can be infected with the AIDS virus. Los Angeles nephrologist Neil R. Schram, who wrote the script for a film on counseling HIV-positive patients, puts it this way: "Health-care work-

ers look at a patient and think, 'He doesn't look like a member of a high-risk group, so I don't have to take any precautions.' That's a very dangerous attitude."

"The way I handle it," adds Atlanta infectious diseases specialist Richard DuBois, "is to tell my staff to regard all blood and body secretions as potentially contagious. I assure them that the risk of HIV infection in their jobs is very small, but it's not zero."

But how do you get assistants to wear gloves with patients they've known for years? "A lot of our staff had trouble putting on gloves for people they'd never used gloves with before," recalls Washington, D.C., internist Lawrence S. McDonald, Jr. "We had to convince them that it wouldn't offend people."

Doctors who've been observing precautions say you're unlikely to meet with patient resistance. In fact, you'll probably find your patients somewhat familiar with such measures as gloves and masks—they may have encountered them already at the dentist's office—and pleased to see you're making your care safer.

I think most patients have always wondered why doctors and nurses do certain things bare-handed, such as having contact with oral secretions," observes Patricia Lynch, RN, infection control coordinator at Harborview Medical Center in Seattle, another institution that has been following guidelines similar to the CDC's. "Wearing gloves makes very good sense to them. People are relieved by the precautions."

Some doctors have even found that patients will encourage office assistants to take precautions. "I've enlisted my patients' support in reminding my staff to observe the standards," says McDonald. "I've told them, 'If you see a nurse taking blood without gloves on, mention the omission to her.' And my patients have been extremely helpful with this."

Of course, you don't want any patient to think you're wearing gloves because you've suddenly begun to suspect *he* has AIDS. So explain briefly that the gloves and other changes are among the stricter measures you and your staff are taking with all patients to prevent the spread of infectious diseases.

Before you put AIDS precautions into effect, consider holding a staff meeting. Internist McDonald suggests including everyone—from nurses to the clerk who processes insurance claims. Tell them that the measures are absolutely necessary, and that patients, far from resenting the precautions, will appreciate your concern.

At the meeting, allow ample time for employees to raise questions about AIDS. Don't underestimate the confusion you may encounter. "You can't assume that because people work in a medical office they're aware of how the virus is spread," notes David G. Ostrow, an Ann Arbor, Mich., psychiatrist and researcher who edited a book called *Biobehavioral Control of AIDS.*

After the initial meeting, gather your staff for periodic updates. McDonald says he has AIDS education sessions for his employees five or six times a year "just to review things for everybody."

For staff members who don't participate in direct patient care, your message should be that there's still no documented risk of HIV transmission by casual contact. Your receptionist doesn't need—and shouldn't be allowed—to wear gloves when she hands a bill to a patient.

You can't promote staff compliance if you don't follow the guidelines yourself."If you follow the recommended precautions, your staff will pick up and imitate that," says psychiatrist Ostrow. "But if you backslide and start doing special things only when a patient who might be HIV-positive walks through the door, you'll be showing your staff how not to follow the guidelines."

To protect yourself legally, document all your safeguards, advises David C. Scroggins, a Cincinnati-based practice management consultant. "You want to be able to show that you had an established policy, that you educated your staff about it, and that you enforced it. You need to have all this down in writing against the possibility of a lawsuit," he says.

To be sure, it's not yet clear to what extent doctors will be held legally accountable for adhering to the CDC guidelines. All that's known now is that the U.S. Department of Labor's Occupational Safety and Health Administration has announced it "will develop targeted inspection plans for hospitals and other health-care facilities" to enforce AIDS precautions.

What if one of your employees does become infected on the job? Could you face a costly lawsuit?

"It's an extremely new area in which there's very little case or statutory law," answers Ronald I. Nagel, an attorney with Health Care Consulting Inc. in Bala-Cynwyd, Pa. "There are many unresolved issues. For example, do the guidelines represent a maximum or a minimum standard of care? If a medical employee becomes infected in the workplace, would she bring a workers' compensation claim or tort suit?"

Most employee-employer suits, Nagel adds, are workers' compensation cases. In many states, workers' compensation awards are limited to lost wages and medical expenses; there's no recovery for emotional distress or pain and suffering.

Still, a doctor who ignores the guidelines could be putting himself at risk of far more than a workers' comp claim. "Can you imagine a jury's response to a nurse who gets infected in an office where the physician doesn't let his staff take any precautions?" asks Scroggins. "Think of what she'd say: 'I asked him about the guidelines, and he refused to comply. He was too cheap to buy a $5 box of gloves.'"

Exchange Insights is not intended to provide legal advice, and no attempt is made to define conduct which would have been appropriate in particular cases to meet acceptable standards of care.

IMJ

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Volume 174, Number 4, October 1988

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REPORT FOR *Illinois Physicians*

SUPPORT FOR SUBMITTING YOUR CLAIMS ELECTRONICALLY

Physicians' claims are currently being electronically submitted to Blue Shield and Medicare "B" by hospitals and service bureaus. Many other physicians utilize their own computer hardware using software developed by vendors.

Physicians and groups whose claims are submitted electronically are realizing the advantages of Electronic Media Claims (EMC) processing. These include:

- Improved Turnaround Time:
 - –Claims processing time can be reduced thus increasing cash flow.
 - –Medicare Part "B" claims will be crossed over for many Blue Shield groups.
- Greater Payment Accuracy:
 - –Submitting claims electronically reduces errors and delays.
- Increased Staff Productivity:
 - –Paper handling is reduced.
 - –Sorting and filing time is reduced.
 - –Mailing cost is substantially reduced.
- Reduced Patient Inquiries:
 - –Faster, more accurate payment results in fewer patient inquiries regarding bills.

If you are not currently submitting claims electronically, but are interested in doing so, you can contact the following Service Bureaus for information:

Arcventures, Inc.
910 West Van Buren-Suite 300
Chicago, Illinois 60607
(312) 942-8381

Chicago Medical Computers, Inc.
2800 West 95th Street
Evergreen Park, Illinois 60642
(312) 425-7227

Creative Billing Services
P.O. Box 558
Alton, Illinois 62002
(618) 465-0100

Cycare Systems, Inc.
1011 East Touhy Avenue-Suite 500
Des Plaines, Illinois 60018
(312) 296-1950

Data Care, Inc.
5000 Cedar Plaza Parkway
St. Louis, Missouri 63128
(314) 843-5515

Express Medi Claims
129 Phelps Avenue-Suite 231
Rockford, Illinois 61108
(815) 397-0780

Facilities Management
601 North Magnolia
Orlando, Florida 32801
(305) 422-9831

Illinois Medical Billing Service
6910 South Madison
Willowbrook, Illinois 60521
(312) 323-1661

IDX
888 Commonwealth Avenue
Boston, Massachusetts 02215
(617) 566-6800

John Mock and Associates, Inc.
4600 West Touhy Avenue
Lincolnwood, Illinois 60646
(312) 675-3600

MD's Billing Service
5868 North Lincoln Avenue
Chicago, Illinois 60659
(312) 769-0117

Medical Management Services
1505 Seventh Street
Moline, Illinois 61265
(309) 762-0973

Medical Payment Systems, Inc.
24601 Center Ridge Road-Suite 300
Westlake, Ohio 44145
1-800-334-2644

National Teledata Corporation
700 Longwater Drive
Norwell, Massachusetts 02061
1-800-262-2089

Physicians Filing Service
1123 Broadway
Mt. Vernon, Illinois 62864
1-800-458-3322

Physicians' Service Center
641 East Butterfield Road
Lombard, Illinois 60148
(312) 960-9222

Prodata
2277 West Howard Street
Chicago, Illinois 60645
(312) 764-6800

Professional Business Offices, Inc.
15 Spinning Wheel Road
Hinsdale, Illinois 60521
(312) 920-1034

SMS/Medical Associates
1515 North Harlem Avenue-Suite 302
Oak Park, Illinois 60302
(312) 383-8372 or (312) 657-7482

Stites Medicare Service (DME)
316 East Washington Street
Macomb, Illinois 61455
(309) 837-6161

Systems Architecture
460 South Northwest Highway
Park Ridge, Illinois 60036
(312) 696-3300

Also, many hospitals in Illinois are submitting claims electronically for physicians. Your hospital's business office may be able to provide assistance or information about submitting your Blue Shield and Medicare "B" Claims.

If you already have the capability and are interested inbilling us directly, or you would like further information on hospitals, system vendors and service bureaus listed, please call us at (312) 938-7697.

MEDICARE NOTES

HOSPICE CARE

Beneficiaries who have a terminal illness with a life expectancy of 6 months or less have the option of electing hospice coverage in lieu of the standard Medicare coverage for their terminal condition. Only hospices which are approved as a Medicare certified hospice are covered under these provisions of the law. Hospice care is available for two periods of 90 days and one period of 30 days in lieu of all other Medicare benefits,except for the service of the patient's attending physician and services not related to the terminal condition. If the patient is in the hospice at the end of 210 days, when the benefits are exhausted, the hospice physician can bill the carrier on a HCFA-1500. His services are reimbursed at 80 percent of the reasonable charge subject to the annual Part B deductible.

The beneficiary who has elected hospice benefits has the option of continuing to use his private physician as his attending physician in addition to using the hospice physician. Services by a private physician are reimbursed at 80 percent of the reasonable charge subject to the deductible. The hospice bills the intermediary for attending physician services provided by its own physicians. Treatment for other than the terminal condition should be billed to Medicare Part B and is reimbursed at 80 percent of the reasonable charge, subject to the deductible, whether the services are provided by a private or a hospice physician.

When billing, private physicians should enter the statement "Hospice Patient, Dr. _____ is the attending physician and is not employed by the hospice" on the HCFA-1500.

OBRA '87 PROVISION FOR PAYMENT FLOORS

The Omnibus Budget Reconciliation Act of 1987 contains a provision which establishes a payment floor for Medicare claims. A payment floor is a specific minimum number of calendar days which must have passed before payment can be made on a claim. Effective July 1, 1988, the payment floor for Medicare B claims is ten (10) calendar days from the date of receipt. No payment will be made on a Medicare B claim until at least ten calendar days have passed from the date the claim was received by the Carrier. The ten-day payment floor will be in effect until September 30, 1988. Beginning October 1, 1988, the payment floor for Medicare B claims will be fourteen (14) days from the date of receipt.

It is important to note that HCFA standards for the timely processing of claims will remain in effect. The timely processing standards that the Illinois Carrier is expected to comply with are as follows:

–95% clean claims within 26 calendar days of receipt for non-participating providers;
–95% clean claims within 19 calendar days of receipt for participating providers.

For fiscal year 1989, which begins October 1, 1988, timeliness standards will change to 25 days for clean claims for non-participating providers, and 18 days for clean claims for participating providers.

PURCHASED DIAGNOSTIC TESTS—ADDITIONAL INFORMATION

As you were informed in our April 1988 Major Mailing (pages 43-45), global billings are no longer accepted when the physician is purchasing the test from an outside supplier.

When a physician purchases a technical component (the services of a technician) from an outside supplier, use the appropriate procedure code for the test, followed by Modifier TC (Technical Component). Indicate the acquisition cost (net any discounts—remember "No Mark-Up"), along with the supplier's name, address, and Medicare B provider number. Box 22 of the HCFA-1500 claim form must be checked "Yes". Either accept assignment or collect only the 20% co-insurance and/or any unmet deductible from the patient.

When billing the professional component (physician's service), use the appropriate procedure code for the test, followed by Modifier 26 (Professional Component), and indicate your charge. **If you are a non-participating physician, your charge is limited to the MAAC shown on your MAAC report in the TOS-D column. If you have no pricing in TOS-D, request that information by procedure code from Medicare B, Freedom of Information, P.O. Box 992, Marion, Illinois 62959.

Outside suppliers may bill separately for the technical component if they choose. In order to do so, they require a Medicare B provider number. In this situation, the physician would bill for the professional component only, as described above, adding the information "Supplier billing separately for technical component." When the supplier is billing directly for the technical component, he/she would bill as described above (for the technical component), using the appropriate procedure code, followed by Modifier TC.

If both professional and technical components of the diagnostic test are personally performed by the physician or by his own employees under his direct supervision, global billing is required. Box 22 on the HCFA-1500 claim form should be checked "No." You do not have to accept assignment when "personally performing." Additionally, if you do not complete a HCFA-1500 claim form for your patients, indicate "personally performed" or "no purchased test" on the statement or superbill you give to your patients. Adding this required information to your statement or superbill will enable Medicare B to pay those patients who file their own claims.

NEW MAXIMUM FOR OUTPATIENT PSYCHIATRIC SERVICES

As of January 1, 1988, the yearly maximum for outpatient psychiatric services was increased from $500 to $900. This provides for a new yearly maximum payment of $450. The formula applied to the $900 maximum is the same as that applied to the previous $500 maximum:

$900 x .625 (62.5%) = $562.50 = Reasonable Charge
$562.50 x .80 (80%) = $450.00 = Maximum Payment

(This report is a service to the physicians of Illinois)

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Illinois State Medical Society

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October 1988

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Let's Continue To Make a Difference



Organized medicine has become so important to the future of health care that I'd hesitate to consider what medical practice would be like without it.

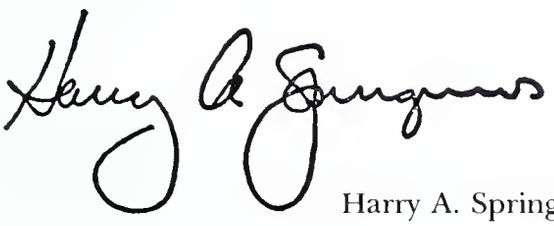
Take for example the last session of the Illinois General Assembly. Legislators considered over 200 bills related to health care. Some, in our judgment, were inimical to the public health. Others represented needless government intrusion. Many favored medicine and benefitted the public good. In all cases, the Society was there to support or oppose, and educate in the process.

Please take a few moments to peruse this reference issue of *IMJ;* like all sourcebooks, it's most useful to the well-acquainted. Take note of the physicians who give their time and expertise on ISMS councils and committees, and the value of their contributions. The council and committee structure is the core of our organizational effectiveness.

This is a very effective way to make a difference, and the experience is enriching to the participants as well. I hope that every member will consider volunteering for one of the Society's councils or committees.

The effectiveness of any organization is defined by the intensity of member involvement. Without the fresh new ideas produced by grassroots activity, our Society would stagnate and lose its relevance.

I hope that each of you will make a commitment to get involved in our professional efforts. The All Member Conference in Springfield on November 4-5 is a fine opportunity to do just that. We need you. Our combined intellect and ability can help us to continue to make a difference. ◀



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- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old Ceclor penetrates mother's milk Exercise caution in prescribing for these patients

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include
- Gastrointestinal (mostly diarrhea) 2 5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever) 1 5%, usually subside within a few days after cessation of therapy Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported
- Other eosinophilia, 2%, genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia

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- Transient fluctuations in leukocyte count (especially in infants and children)
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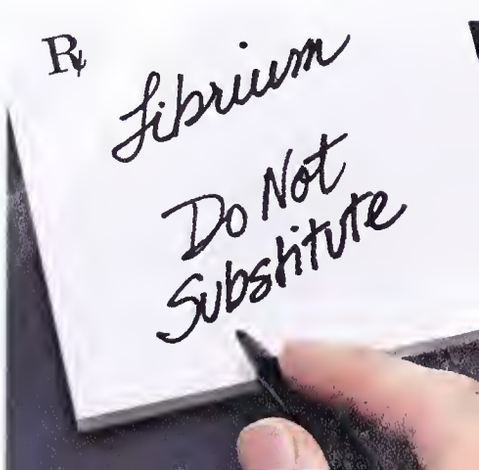
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OBITUARIES

Coleman, Barrett L., East St. Louis, died April 7, 1988, at the age of 47. Dr. Coleman was a 1965 graduate of the Indiana University School of Medicine, Indianapolis.

Cserny, Andrew, Eldorado, died December 14, 1987, at the age of 82. Dr. Cserny was a 1933 graduate of Institutul de Medicina si Farmacie, Bucuresti, Romania.

****Herst, Mark J.,** Skokie, died April 30, 1988, at the age of 35. Dr. Herst was a 1979 graduate of the University of Illinois College of Medicine, Chicago.

***Kassaraba, Walter A.,** Chicago, died July 15, 1988, at the age of 71. Dr. Kassaraba was a 1945 graduate of Medizinische Fakultat der Universitat Wien, Wien, Germany.

****Lueth, Harold C.,** Evanston, died May 12, 1988, at the age of 83. Dr. Lueth was a 1930 graduate of Northwestern University School of Medicine, Chicago.

***Pernot, Robert D.,** Centralia, died May 25, 1988, at the age of 47. Dr. Pernot was a 1970 graduate of the University of Wisconsin Medical School, Madison.

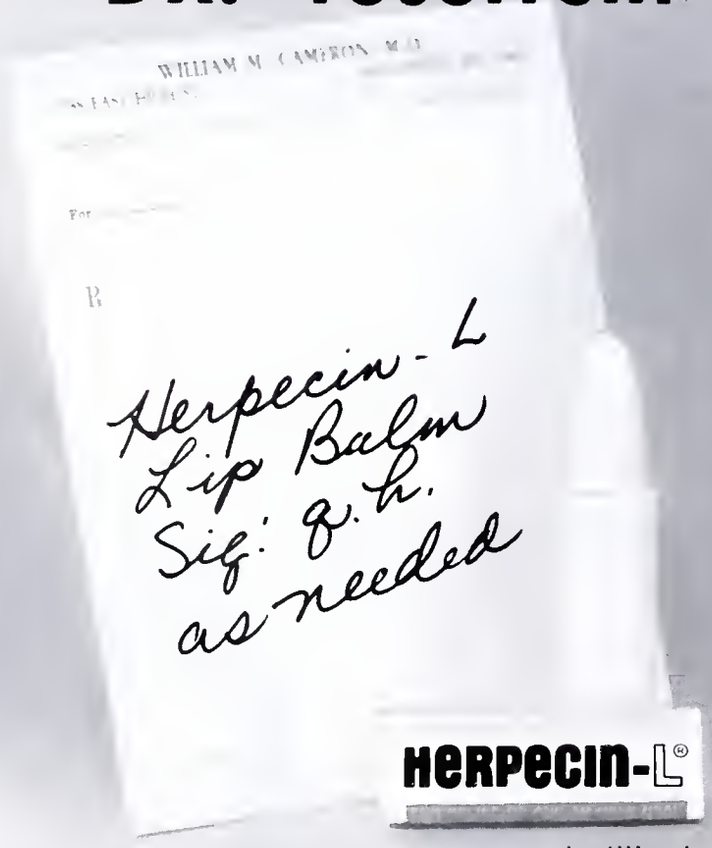
Robertson, Robert C., Evanston, died March 24, 1988, at the age of 63. Dr. Robertson was a 1948 graduate of the University of Illinois College of Medicine, Chicago.

***Robinson, Walter K.,** Lombard, died May 28, 1988, at the age of 83. Dr. Robinson was a 1942 graduate of the University of Illinois College of Medicine, Chicago.

****Whitfield, Harvey, J.,** Chicago, died May 12, 1988, at the age of 82. Dr. Whitfield was a 1935 graduate of Meharry Medical College School of Medicine, Nashville, Tennessee.

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**Indicates member of ISMS Fifty Year Club

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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 782-1654.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

November

Family Medicine, Geriatrics, Internal Medicine

Aging and Illness in Primary Care: The 6th Symposium on Issues in the Care of the Old-Old
For: Physicians and other health care workers. Symposium: November 3-4, Madison, WI. **Sponsor:** University of Wisconsin-Madison, Continuing Medical Education, 2715 Marshall Court, Madison, WI 53705. Cosponsors: Dept. of Medicine, University of Wisconsin Medical School and Geriatric Section, William S. Middleton Memorial Veterans Hospital. **Fee:** TBA. **Reg. limit:** None. **Credit:** Category 1: 14 hours; AAFP Elective: 14 hours; AOA Category 2-D: 14 hours. **Contact:** Cathy Means, Program Coordinator. **Phone:** (608) 263-6637.

General Practice, Internal Medicine

Coronary Heart Disease: Current Concepts
For: General practitioners, internists. Lecture/workshop: November 11-12, Chicago, IL. **Sponsor:** Medical Education Resources, 5808 South Rapp Street, Suite 202, Littleton, CO 80120. **Fee:** $295. **Reg. Limit:** 40. **Credit:** Category 1: 11 hours; AAFP prescribed: 11 hours. **Contact:** Deborah Wilderson. **Phone:** (800) 421-3756 (outside Colorado); (303) 798-9682 (in Colorado).

Hematology/Oncology

Antidote to Adjuvant—The Changing Role of Leucovorin in Clinical Oncology
For: Hematologists and oncologists. Symposium: November 9, Chicago, IL. **Sponsor:** The University of Chicago School of Medicine, Center for Continuing Medical Education, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 3 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Infectious Diseases

3rd Annual Conference on Concepts and Controversies in Infectious Diseases
For: Pharmacists, physicians and microbiologists involved in treatment of infectious diseases. Conference: November 18, Chicago, IL. **Sponsor:** The University of Illinois College of Pharmacy (Dept. of Pharmacy Practice and Office of Continuing Education) and College of Medicine (Section of Infectious Diseases), c/o Conferences and Institutes (m/c 607), 912 S. Wood, Chicago, IL 60612. **Fee:** $35. **Credit:** Category 1: 5 hours. **Contact:** Conference Registrar. **Phone:** (312) 996-5225.

Internal Medicine

Advances in Internal Medicine, 1988
For: Internists. Lecture: November 7-11, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $550. **Reg. Limit:** None. **Credit:** Category 1: 32 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Neurology

Neuroimmunology VI
For: Neurologists. Course: November 3-5, Chicago, IL. **Sponsor:** The University of Chicago School of Medicine, Center for Continuing Medical Education, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** 100. **Credit:** Category 1: 18 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Ophthalmology

Glaucoma Management for the 90's
For: Ophthalmologists. Conference: November 4-5, Chicago, IL. **Sponsor:** UIC College of Medicine, Dept. of Ophthalmology, 912 S. Wood Street, 2nd Floor North (m/c 607), Chicago, IL 60612. **Fee:** $250. **Reg. Limit:** 200. **Reg. Deadline:** October 21. **Credit:** Category 1: 10 hours. **Contact:** Sue Talbert. **Phone:** (312) 996-4631.

Laser for Common Fundus Diseases: A Workshop on the Why, When, and How of Treatment
For: Ophthalmologists. Workshop: November 18-19, Madison, WI. **Sponsor:** University of Wisconsin-Madison, Continuing Medical Education and Dept. of Ophthalmology, 2715 Marshall Court, Madison, WI 53705. **Fee:** TBA. **Reg. Limit:** 50. **Credit:** Category 1: 17 hours. **Contact:** Cathy Means, Program Coordinator. **Phone:** (608) 263-6637.

Phacoemulsification Workshop
For: Ophthalmologists. Lecture/wet lab: November 5, Chicago, IL. **Sponsor:** UIC College of Medicine, Dept. of Ophthalmology, 912 S. Wood Street, 2nd Floor North (m/c 607), Chicago, IL 60612. **Fee:** $100. **Reg. Limit:** lecture: none; wet lab: 50. **Reg. Deadline:** October 21. **Credit:** Category 1: 4 hours. **Contact:** Sue Talbert. **Phone:** (312) 996-4631.

Otolaryngology, Oculo-plastic and Plastic Surgery

For: Otolaryngologists, oculo-plastic and plastic surgeons, anaplastologists, maxillofacial prosthodontists, head, neck, limb prosthetists. Lectures and workshops: November 5-7, Chicago, IL. **Sponsor:** University of Illinois at Chicago, College of Medicine and College of Associated Health Professions, c/o Conferences and Institutes (m/c 607), 912 S. Wood, Chicago, IL. Cosponsor: American Anaplastology Association. **Fee:** $250 for all sessions. **Reg limit:** None. **Reg. deadline:** October 21. **Credit:** Category 1: 16 hours. **Contact:** Audrey Tamosiunas, Program Coordinator. **Phone:** (312) 996-5749.

Sports Medicine

Sports Medicine for the Primary Care Physician
For: Generalists in pediatrics, family medicine, internal medicine and emergency medicine. Lecture: November 16-18, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $400. **Reg. Limit:** 90. **Credit:** Category 1: 24 hours; ACEP applied for. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Surgery

Flexible Fiberoptic Sigmoidoscopy
For: Surgeons. Lecture: November 12, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $160. **Reg. limit:** 75. **Credit:** Category 1: 7 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 (in Illinois); (800) 621-4651 (outside Illinois).

Trauma

36th Annual Detroit Trauma Symposium
For: Surgeons, critical care personnel. Symposium: November 11-12, Detroit, MI. **Sponsor:** Wayne State University, Dept. of Surgery, c/o Harper Hospital, Dept. of Surgery, 3990 John R, Detroit, MI 48201. **Fee:** $130 for practicing physicians; $80 for physicians in training and allied health personnel. **Reg. limit:** None. **Credit:** Category 1: 9 hours; AOA approved. **Contact:** Marjorie Norum. **Phone:** (313) 745-2345.

Advanced Trauma Life Support
For: Surgeons and emergency physicians. Course: November 18-19, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Towsley Center for CME, Ann Arbor, MI 48109-0201. **Fee:** $595. **Reg. limit:** 32. **Credit:** Category 1: 18 hours; AOA: applied for. **Contact:** Karen Brown. **Phone:** (313)763-1400 or (800)962-3555.

December

Cardiology

Lipoprotein (a): 25 Years of Progress
For: Cardiologists. Symposium: December 2-3, Chicago, IL. **Sponsor:** The University of Chicago School of Medicine, Center for Continuing Medical Education, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** TBA. **Reg. limit:** 150. **Credit:** Category 1: 10 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Neurology

Neurology for the Non-Neurologist
For: Family practitioners, internists, psychiatrists. Lecture/Workshop: December 7-9, Chicago, IL. **Sponsor:** Rush-Presbyterian-St. Lukes's Medical Center, Continuing Medical Education, 600 S. Paulina, Chicago, IL 60612. **Fee:** $400. **Reg. limit:** None. **Credit:** Category 1: 20 hours. **Contact:** Continuing Medical Education. **Phone:** (312) 942-7095.

Obstetrics and Gynecology

Problem Solving in Gynecologic Endocrinology and Infertility
For: Obstetricians and gynecologists. Symposium: December 9-10, Chicago, IL. **Sponsor:** The University of Chicago School of Medicine, Center for Continuing Medical Education, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** TBA. **Reg. limit:** 200. **Credit:** Category 1: 10 hours; ACOG: 10 cognates. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Ophthalmology

Current Concepts in Pneumatic Retinopexy
For: Ophthalmologists. Symposium/lecture/conference: December 10, Chicago, IL. **Sponsor:** The University of Illinois at Chicago Eye Center, c/o Conferences and Institutes (m/c 607), 912 S. Wood Street, Chicago, IL 60612. **Fee:** $195. **Reg. limit:** 200. **Reg. deadline:** November 23. Credit: Category 1: 7 hours. **Contact:** Sue Talbert, Program Coordinator. **Phone:** (312)996-4631.

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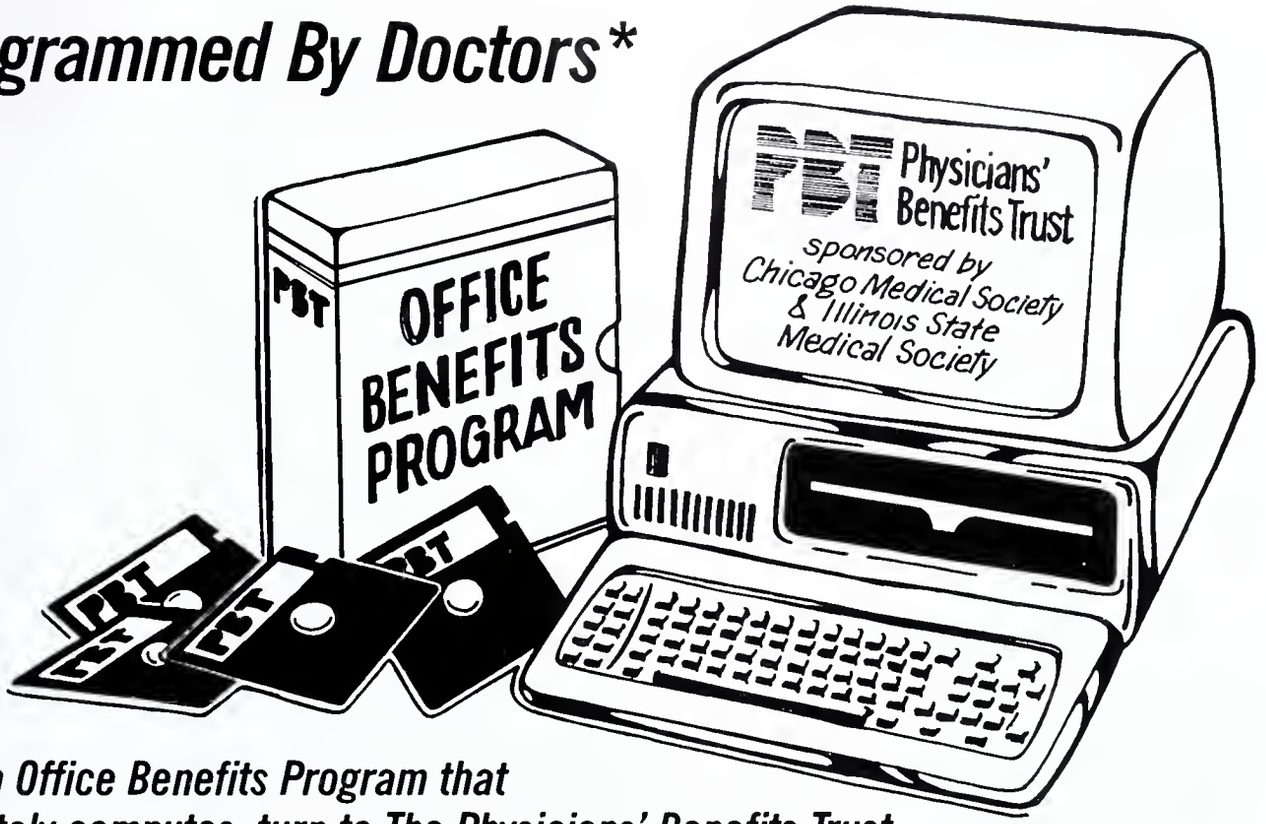
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ISMS Physician Help Line

Are you troubled by chemical dependency, alcoholism, physical or mental problems, or concerned about someone who has an impairment? Are you having emotional or physical problems dealing with your involvement in a malpractice suit?

If so, contact the PHYSICIAN HELP LINE, 312/580-2499, a confidential, advocacy service offered by the ISMS Physician Assistance Program and the Physician Support Group to link troubled physicians and their families with resources to help them.

Physician Help Line calls will be answered, as soon as possible, by Dr. Violet M. Eggert, Medical Director of the ISMS Physician Assistance Program.

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Computers in Medical Practice Today: Succeeding in a Changing Health Care Environment
November 4-5, 1988
Advances in Internal Medicine, 1988
November 7-11, 1988
Flexible Fiberoptic Sigmoidoscopy
November 12, 1988
Fiberoptic Esophagogastric Endoscopy
November 14-16, 1988
Sports Medicine for the Primary Care Physician
November 16-18, 1988
Specialty Review in Thoracic Surgery
January 9-14, 1989
Review Course in Neurological Surgery
February 3-12, 1989
The Biologic Basis of Neurology and Psychiatry: A Review for Board Candidates and Established Practitioners
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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85

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Helps angina patients get more out of life

Significantly reduces both the frequency of anginal attacks and the need for sublingual nitroglycerin[1]

Preferred by patients over 7 to 1 for convenience compared to their previous long-acting oral nitrate; only 12% had no preference (n = 4,300)[2]

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. Please consult brief summary of Prescribing Information on the following page.

CIBA

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Transderm-Nitro® nitroglycerin
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest, if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response.
The Transderm-Nitro 2.5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

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C I B A

References:
1. Martines C: Comparison of the prophylactic anti-anginal effect of two doses of Nitroderm TTS in out-patients with stable angina pectoris. *Curr Ther Res* 1984;36:483-489.
2. Brady EM, Gold OG, Rosenbach H: Transdermal nitroglycerin antianginal comparative trial involving oral nitrates: The Transderm-Nitro A.C.T.I.O.N. Study. Presented at 2nd Cardiovascular Pharmacotherapy International Symposium. San Francisco, October 1987.

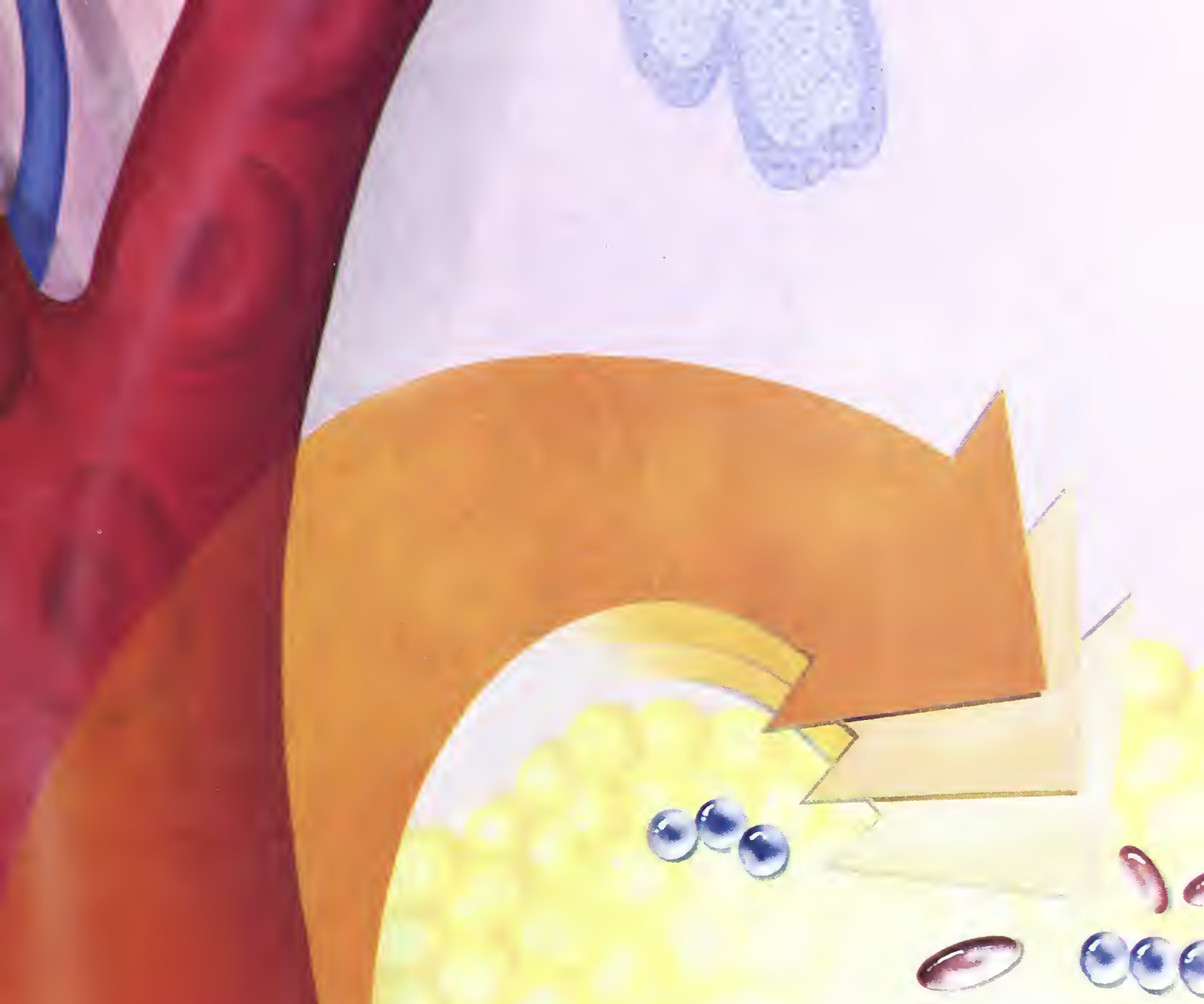
SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies. This information was gathered through correspondence or by ISMS representatives and staff who attend meetings on behalf of Illinois physicians.

From the Department of Professional Regulation

Disciplinary Actions

- *Richard R. Adams, M.D.:* (lic. # 036-056152)
 Effective June 20, 1988, Dr. Adams' medical license was suspended.
- *Michael J. Asirvatham* (lic. # 036-054522)
 Effective July 27, 1988, Dr. Asirvatham's medical license was suspended for 6 months.
- *Miro Bliandzic* (lic. # 036-048647)
 Effective August 7, 1988, Dr. Bliandzic's medical license was reprimanded and he was fined.
- *Leonard J. Brooks, M.D.:* (lic. # 036-034402)
 Effective June 20, 1988, Dr. Brooks' medical license was suspended.
- *Michael E. Dillon* (lic. # 036-068150)
 Effective August 10, 1988, Dr. Dillon's medical license was placed on a 2 year probation.
- *Ezzeldin I. Eraiba, M.D.:* (lic. # 036-051624)
 Effective June 30, 1988, Dr. Eraiba's medical license was suspended indefinitely.
- *Gerald Horn, M.D.:* (lic. # 036-058055)
 Effective June 30, 1988, Dr. Horn was fined and reprimanded.
- *David L. Levine, M.D.:* (lic. # 036-043207)
 Effective August 10, 1988, Dr. Levine's medical license was reprimanded.
- *Jules H. Masserman, M.D.:* (lic. # 036-021530 & 003-036-021530)
 Effective October 23, 1987, Dr. Masserman's medical license was surrendered.
- *Robert Nelson, M.D.:* (lic. # 036-073446)
 Effective June 30, 1988, Dr. Nelson was fined and his license placed on probation.
- *Samir A. Osman, M.D.:* (lic. # 036-052026)
 Effective July 25, 1988, Dr. Osman's medical license was revoked.
- *Humberto Otero* (lic. # 036-054166)
 Effective August 20, 1988, Dr. Otero's medical license was indefinitely suspended.
- *Barry P. Schneiderman, M.D.:* (lic. # 036-043570)
 Effective June 20, 1988, Dr. Schneiderman's medical license was suspended.
- *Krishna Yemmanur, M.D.:* (lic. # 036-065336)
 Effective June 20, 1988, Dr. Yemmanur's medical license was placed on probation.



Penetration plus Duration*

Superior tissue penetration and duration of action

DURICEF®

(CEFADROXIL)

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*May not correlate with clinical results.

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For Brief Summary, please see following page.

DURICEF® (CEFADROXIL)
Penetration plus Duration
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INDICATIONS: DURICEF (cefadroxil) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms. Urinary tract infections caused by *E. coli*, *P. mirabilis*, and *Klebsiella* species. Skin and skin structure infections caused by staphylococci and/or streptococci. Pharyngitis and tonsillitis caused by Group A beta-hemolytic streptococci. (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. DURICEF is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of DURICEF in the subsequent prevention of rheumatic fever are not available at present.)

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

CONTRAINDICATIONS: DURICEF is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF PENICILLINS AND CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE).

Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil). **Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.** Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated. When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should also be considered.

PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

DURICEF (cefadroxil) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 ml/min/1.73M^2). (See Dosage and Administration section of Prescribing Information.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.

Prolonged use of DURICEF may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug. DURICEF should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to 11 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cefadroxil. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Caution should be exercised when cefadroxil is administered to a nursing mother.

ADVERSE REACTIONS: *Gastrointestinal*—Symptoms of pseudomembranous colitis can appear during antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug.

Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.

Before prescribing or administering, see package insert.

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

CHICAGO SUBURBAN:

MacNeal Hospital, a major teaching affiliate of Rush-Presbyterian-St. Luke's Medical Center, seeks family practitioners and obstetricians. Opportunities include private practice, solo, partnership, practices for sale, salaried positions. Individualized comprehensive financial package. BE/BC family practice; OB/BC family practice; OB/GYN. Forward CV: Physician Affairs, 3249 S. Oak Park Avenue, Berwyn, IL 60402. (10)

FLORA:

Small, progressive hospital in southern Illinois seeks family practitioner. Beautiful small town, scenic area, yet only an hour's drive from major metropolitan areas. Financial assistance and office space available. Contact: John E. Monnahan, Administrator, Clay County Hospital, 700 North Mill, Flora, IL 62839; (618) 662-2131 ext. 228. (9)

HAZEL CREST:

South Suburban Hospital has immediate opportunity for board certified, or board eligible family practitioner/internist. Physician will assume control of well established practice of retiring physician. Relocation allowance; loan guarantees; marketing support available. Will consider candidates currently finishing residency. For this and other practice opportunities, direct C.V. to Joe Dwyer, Vice-President Marketing, South Suburban Hospital, 17800 S. Kedzie, Hazel Crest, IL 60429. (9)

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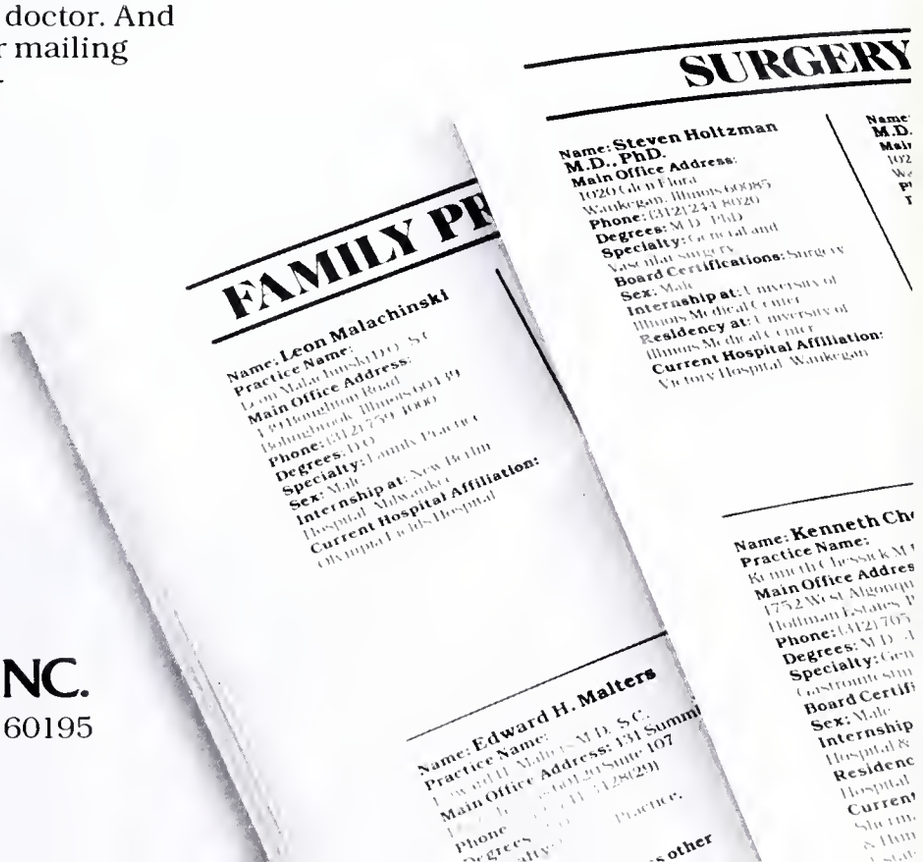
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IMJ

Illinois Medical Journal
Illinois State Medical Society
Volume 174, No. 4
October 1988

ISMS Organization

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp, who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected to fill the post in May, 1968. He was succeeded by Mr. Alexander R. Lerner, in May, 1981. In 1988 the position was retitled Executive Vice President. Another milestone was reached in October, 1984, when the headquarters offices relocated to Twenty North Michigan Avenue, Chicago 60602.

The Society published early transactions in book form, presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. VanDellen was the editor for 18 years ending 1977. Subsequently, an Editorial Board was established under chairmanship of Dr. J. William Roddick, Jr., to review and determine clinical content for the *IMJ*. Dr. Roddick completed his term as chairman in June of 1987. The Editorial Board reports to the ISMS Publications Committee.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938. Illinois also led the way for medical participation in political action when it formed the first medical political action committee, IMPAC, in 1960. The Illinois State Medical Inter-Insurance Exchange, an insurance reciprocal providing comprehensive professional liability insurance for Illinois physicians, was formed in 1976. Concomitantly, Illinois State Medical Insurance Services, Inc., was formed as a wholly-owned subsidiary of ISMS to act as Attorney-in-Fact for the Exchange.

In 1988, an exhaustive study of the Society's communication needs, generated by the results of a January 1987 all-member survey, brought the Board of Trustees to authorize a new flagship publication. Survey results had shown that clinical papers were no longer the first responsibility of ISMS communications; specialty society publications and national books had come to be regarded as more important sources. ISMS members made it clear that they expected the Society to provide timely news and comment on socio-economic events affecting medical practice in Illinois. For these reasons, the Society would initiate publication in January 1989, of *Illinois Medicine*, a twice-monthly newspaper carrying information about medicine and healthcare issues in Illinois.

One of the largest state medical societies in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

ISMS Code of Ethics

WHEREAS, The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient; and

WHEREAS, As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals and to self; therefore be it

RESOLVED, That the following Code of Ethics be adopted by the Illinois State Medical Society not as laws, but standards of conduct which define the essentials of honorable behavior for the physician:

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences, within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Adopted by the Illinois State Medical Society
House of Delegates
November, 1981

Illinois State Medical Society Constitution and Bylaws

Adopted, 1903
As Amended, 1988

Constitution

Article I. Name

The name and title of this organization shall be the Illinois State Medical Society.

Article II. Purposes of the Society

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

Article III. Component Societies

Component societies shall consist of those county medical societies which hold charters from this Society.

Article IV. Composition of the Society

The Society shall consist of active members and such other members as the Bylaws may provide.

Article V. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

Section 3. The House of Delegates shall elect members to serve on the Judicial Panel. The Judicial Panel shall perform all judicial functions on behalf of the Illinois State Medical Society, shall review all questions of ethics and shall interpret all rules and regulations of the Society. Further, it shall conduct all hearings on appeals taken from decisions of component medical societies, arising out of disciplinary actions against physicians.

Article VI. Officers

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, and such trustees and other officers as the Bylaws may provide.

Article VII. Board of Trustees

The Board of Trustees, whose duties are executive, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

Article VIII. Conventions and Meetings

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

Article IX. The Seal

This Society shall have a common seal with power to break, change or renew the same when necessary.

Article X. Amendments

The House of Delegates may amend this Constitution at any annual or interim business meeting of the House of Delegates provided that the amendment shall have been proposed at a preceding annual or interim business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. Members. Members shall consist of Regular members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. Regular Members. Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principally in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

B. Emeritus Members. Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.

C. Retired Members. Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions in the health care field after retiring from medical practice.

D. Service Members. Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.

E. Distinguished Members. Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

F. In-Training Members. In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

G. Student Members. Student member are those who are currently enrolled i an Illinois medical school or are Illinoi residents enrolled in an approved medi cal school within the boundaries of th United States, are of good moral charac ter, professional and academic standing and student members of a componen society.

Section 2. Discrimination of Membership. Membership in the Illinois State Medica Society shall not be denied or abridgec because of color, creed, race, religion, sex o ethnic origin.

Section 3. Tenure and Termination.

A. Tenure of Membership. The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be *prima facie* evidence of membership so long as he complies with the provisions of this Constitution and Bylaws. A member shall hold only one type of membership at any one time.

B. Termination of Membership. Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Suspension will in no way affect insurance benefits.

A member whose dues are unpaid by March 31 of the current year ceases to be in good standing and shall be notified of his delinquency by the secretary. A member whose dues or assessments remain unpaid on April 30 of the current year shall automatically be dropped from membership. An individual who has forfeited membership for non-payment of dues or assessments may be reinstated as a member before two years have elapsed, providing, in the interim, he has not been guilty of conduct prejudicial to membership, by the full payment of all dues or assessments in arrears from the date that he was last in good standing. If two or more years have elapsed since he was a

member in good standing, he will be required to make application as a new member.

Any member in good standing who resigns voluntarily by December 31 of any year may be reinstated within one year of his resignation by paying all dues and assessments that fell due during the period that his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. Any past member who regains membership by payment of all dues and assessments in arrears shall be eligible for membership benefits only to the extent and in the same manner as a new member initially joining the society.

CHAPTER II. DUES AND ASSESSMENTS

Section 1. Dues. Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal.* Only Regular, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

Section 2. Reduction and Remission of Dues. Regular members may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member based upon annual review and recommendation of the component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. Assessments. In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

CHAPTER III.
EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. Composition. The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-Elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, 8) one delegate elected by the Resident Physicians Section, 9) one delegate elected by the Medical Student Section and 10) one delegate elected by the Hospital Medical Staff Section.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, members of the Illinois delegation to the AMA who are not otherwise voting members of the ISMS House of Delegates, and one representative from each recognized medical specialty society, as approved by the ISMS Board of Trustees.

Section 2. Delegates. Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. Affiliate Group Delegates. There shall be a Resident Physicians Section and a Medical Student Section, which shall be open, respectively, to all in-training and medical student members of ISMS. There shall be a Hospital Medical Staff Section, which shall be comprised of ISMS members elected to represent individual hospital medical staffs. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. Time and Place of Meetings.

A. Annual Meeting. The House of Delegates shall meet in an annual session and may meet in an interim session upon call of the Board of Trustees. The time and place of the annual meeting shall be as the House determines.

B. Interim Meeting. The Board of Trustees may schedule an interim session of the House of Delegates between annual meetings of the House if it determines that there is sufficient, relevant business. An interim meeting of the House should not exceed three days and its business shall be restricted in accordance with the provisions of Section 11 of this chapter. An interim meeting should be held in a district other than that of the preceding annual meeting.

Section 5. Quorum. Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. Special Meetings. Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. Registration. Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. District Division. The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. Order of Procedure. The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. Privilege of the Floor. The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. Introduction of Resolutions and Other Business. All resolutions must be introduced by a voting member of the House. Resolutions submitted nine weeks prior to the annual or interim meeting of the House will be listed in the delegates handbook citing author and subject only; a full copy of all resolutions will be mailed to the

delegates. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be received at ISMS headquarters 30 days prior to the annual or interim meeting. Resolutions received after the above date must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. The only business to be considered by the House of Delegates during an interim meeting will be:

1. Resolutions and information reports introduced by the Board of Trustees as urgent business.
2. Resolutions on matters of national importance and considered urgent introduced by a voting member of the House of Delegates on behalf of the AMA delegation under the same conditions as below.
3. Resolutions introduced by individual delegates, by the Resident Physicians Section, or by the Medical Student Section which are considered urgent and accepted by the Committee on Rules and Order of Business.

Decisions of the Committee on Rules and Order of Business regarding the introduction of resolutions at the Interim Meeting may be overruled by a majority of the House of Delegates. Resolutions which are not considered urgent will be carried over to the next annual meeting.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

Section 12. Judicial Panel. The House of Delegates shall create a Judicial Panel and shall elect five (5) of its active members to serve on the Panel, in a manner set forth in Chapter XI of these Bylaws. The Judicial Panel shall review all questions of ethics and shall interpret the laws and rules of the Society. It shall consider all questions of an ethical nature and it shall conduct hearings on appeals taken from decisions of component societies on ethical relations matters and other disputes involving the rights and privileges of physicians.

CHAPTER V. ELECTION OF OFFICERS

Section 1. Officers. The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large, and delegates and alternate delegates to the American Medical Association.

Section 2. Elections. All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and unfinished business at the final session of the House of Delegates.

Section 3. Terms of Office. The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

Delegates and alternate delegates to the AMA shall be elected by the House of Delegates for two-year terms, except in the event of their election to fill a portion of another's unexpired term.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. The President. The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform other duties as custom and parliamentary usage may require. He shall also appoint such task forces as may be needed by the Society.

Section 2. The President-Elect. The President-Elect shall attend all meetings of the Board of Trustees and the Executive Committee, shall study the relationship between the Chairman of the Board and the President and shall study the responsibilities and duties of the Executive Vice President, Chairman of the Board and President so that when his term as President commences, he will have an understanding of his duties and responsibilities. He shall also serve as chairman of the Committee on Planning and Priorities.

Section 3. The Vice Presidents. The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice presidency, the second vice president will become first vice president.

Section 4. Successor to President-Elect In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at such time recommended by the Reference Committee on Rules and Order of Business.

Section 5. The Speaker. The Speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. The Vice Speaker. The vice speaker shall preside for the speaker in the latter's absence or at his request. In case of death or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. The Secretary-Treasurer. In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom, or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

Section 8. Delegates and Alternate Delegates to the American Medical Association. Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies established by the ISMS House of Delegates as they pertain to the AMA activities.

They shall have the privilege of the floor in the ISMS House of Delegates.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. Composition. The Board of Trustees shall consist of twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in the absence of the chairman, shall serve as an ex officio member of the Board of Trustees without vote. The chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange and the chairman of the Board of Directors of the Illinois State Medical Insurance Services, Inc., shall sit as an ex-officio member having all privileges except the right to vote. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—DuPage County.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

Section 2. Duties. The duties of the Board of Trustees are executive and custodial.

A. Executive Duties. The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. Custodial Duties. The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board. The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective. Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

Section 3. Executive Vice President. The Board of Trustees shall employ an Executive Vice President whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the executive vice president. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. Meetings. The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. Organization.

A. Chairman. The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

B. Duties of the Chairman. The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board. He supervises the work of the Executive Vice President appoints members of councils and committees with approval of the Board, and monitors execution of Board decisions and resolutions. He may delegate any of his duties.

Section 6. Quorum. Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. County Societies. The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. Publication. The Board of Trustees shall provide and superintend the publication and distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. Bonding. The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. Duties of Trustees. Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. Vacancies. If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. The Benevolence Fund. Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem appropriate to be held in a fund of a separate incorporated entity known as "The Illinois State Medical Benevolence Fund, Inc." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. Contributions and bequests to the Illinois State Medical Benevolence Fund, Inc., shall be deposited forthwith in said fund.

Section 13. Audit and Financial Statement. The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district; except that district committees may be assigned to act when the Ethical Relations or Peer Review Committees of the component society fail to act as set forth in Chapters XI and XII of these bylaws.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Physicians elected to district committees shall serve a three year term of office. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1. Committee Structure. The committee structure of the Illinois State Medical Society shall be as follows:

A. Councils (standing committees)
B. Committees Reporting Directly to the Board of Trustees
C. House of Delegates Committees
D. Board of Trustees Committees

Section 2. Councils.

A. The Medical-Legal Council shall be concerned in the areas of:
 1. Liaison with the Illinois Bar Association
 2. Liaison with courts, particularly where impartial medical testimony is involved.
 3. Implementation of the Impartial Medical Testimony Rule
 4. Legal aspects of medical practice other than in the area of mental health
 5. Licensing and standards of practice
 6. Quackery
 7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:
 1. Federal and state legislation—analysis and communication
 2. Legislative liaison—both state and federal
 3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:
 1. Liaison with medical schools, curricula, etc.
 2. Health manpower and training
 3. Internships, residencies, etc.
 4. Scientific assembly
 5. Student loans
 6. Continuing medical education

D. The Council on Economics shall be concerned in the areas of:
 1. Ongoing relationships with third parties
 2. Health care cost and utilization

E. The Council on Medical Service shall be concerned with:
 1. The provision of medical care and health services in the public and private sectors
 2. Emergency medical services
 3. Health care of the poor, aged and those in rural areas
 4. Maternal and child health
 5. Nutrition
 6. Workmen's compensation
 7. Environmental and community health
 8. Rehabilitation
 9. Health care facilities and delivery systems

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:
 1. Publicity and promotion
 2. News media relations
 3. Exhibits and public service programming
 4. Religion and medicine
 5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:
 1. Facilities and services
 2. Liaison with Department of Mental Health
 3. Legal aspects of commitment, etc.
 4. Narcotics and dangerous drugs
 5. Alcoholism

Section 3. Organization of Councils.

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by the Governing Council of the ISMS Medical Student Section and resident physician members nominated by the Governing Council of the ISMS Resident Physicians Section may be appointed by the Board of Trustees as members of any appropriate council or committee. Such members shall be permitted full privileges of committee membership, including the right to vote. Members of the Board of Trustees may serve as advisory members to any council or committee.

 Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

 A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils and task forces, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

Section 4. Task Forces. A task force, an ad hoc body to address a specific complex issue and report by a date certain to the Board of Trustees, shall be appointed by the President upon direction of the House of Delegates or request of the Board of Trustees. It shall consist of persons from any two or more of the following categories: council members, committee members, other members of the Society, non-members of the Society. It shall be dismissed upon making its final report.

Section 5. Committees Reporting Directly to the Board of Trustees.

A. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as chairman of the committee.

B. Committee on Health Planning. The committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The committee shall maintain liaison with various organizations as determined by the Board of Trustees.

C. Committee on Drugs and Therapeutics. The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

D. Health Data Committee. The Committee shall maintain ongoing awareness of (1) systems for the collection and dissemination of health care data, (2) government, third party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes, health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of various organizations as determined by the Board of Trustees.

E. Peer Review Appeals Committee. This committee shall serve as an appellate body for state peer review by considering cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relation issues. The committee will serve as liaison to local peer review committees and monitors activities around the state.

F. Committee on CME Accreditation. It shall be the responsibility of this committee to adopt necessary procedural rules and to prescribe forms to be used in the conduct of CME accreditation. The committee shall review sponsor applications and survey team reports for intrastate CME sponsors, and make decisions on grant of initial accreditation and continuation of accredited status.

G. Physician Assistance Committee. The Physician Assistance Committee consists of physicians who provide assistance to physicians and those concerned about them for problems related to alcohol or drug dependence, physical disabilities, mental or emotional disturbances. The Committee provides information, sponsors educational programs, offers counseling, conducts interventions, provides monitoring and serves as the recovering physician's advocate. All activities are provided in a confidential and professional manner.

Section 6. House of Delegates Committees. House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consist of five members nominated by the Speaker and confirmed by the House immediately prior to the conclusion of business at its annual meeting. The committee will serve until the next annual meeting.

It shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates. It shall also consider late resolutions for introduction at the annual meeting and resolutions introduced by individual delegates at the interim meeting.

C. Committee on Tellers and Sergeants-at-Arms shall:
1. Serve the speaker of the House of Delegates.
2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive vice president, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

G. Judicial Panel Committee. The Panel, whose members are nominated by the President and elected by the House of Delegates, adjudicates disputes arising from charges of unethical or illegal practices. The panel accepts appeals after a case has been heard at the county or district level.

Section 7. Organization of House of Delegates Committees.

A. Immediately after the organization of the House of Delegates at each meeting, the speaker shall announce the appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 8. Board of Trustees Committees. The Board of Trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. If the immediate past chairman of the Board is no longer a trustee, the chairman of the Policy Committee shall be a member of the Executive Committee. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, and the speaker of the House of Delegates, or the vice speaker in his absence, shall serve as ex-officio members of the Executive Committee without vote. The chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange and the chairman of the Board of Directors of the Illinois State Medical Insurance Services, Inc., shall sit as an ex-officio member of the Executive Committee without vote.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society. This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence program to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Committee on Constitution and Bylaws shall consist of five members—the Speaker of the House and four members appointed by the Chairman of the Board. It shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

E. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal.*

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal.* It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal.*

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

F. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

G. CME Accreditation Appeals Panel. The panel will consist of seven trustees. It will function as a hearing committee when a CME sponsor appeals a decision of the CME Accreditation Committee. The hearing shall be conducted in conformance with written procedures adopted by the Board of Trustees.

H. The Building and Capital Equipment Committee shall consist of the Chairman of the Board, the President, the President-Elect, the Secretary-Treasurer, the Chairman of the Finance Committee, and the Immediate Past Chairman of the Board, provided that person is a Trustee.

I. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

J. Committee on Insurance. This committee will review society-sponsored insurance programs, study these plans, make suggestions for changes, additions and cancellation of policies, and will investigate other insurance programs that may benefit society members.

K. Third Party Payment Processes Committee. This committee will report to the Board on matters of socioeconomic import which are assigned by the chairman.

Section 9. Powers of the Board of Trustees. The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 10. Term of Membership. The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws of ISMS and the constituent society.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Judicial Panel.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving his application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 11. Members of the Illinois State Medical Society shall be bound by the Constitution and Bylaws of ISMS.

CHAPTER XI. ETHICAL RELATIONS

Part 1. Component Medical Society. Each component society may have, either by appointment or election, an Ethical Relations Committee whose duty it shall be to conduct disciplinary hearings under this chapter. Although the component society may develop its own procedures for conducting such hearings, each society will, to the extent possible, comply with the general guidelines set forth by the Judicial Panel, which panel is created under this chapter; such guidelines referred to as the *Handbook for the Conduct of Disciplinary Proceedings.*

Part 2. District Ethical Relations Committee. The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Ethical Relations Committee. The component society may elect to request that the District Ethical Relations Committee serving its area function in its behalf and shall conduct such disciplinary proceedings as are required. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold a hearing on a properly filed complaint, within a reasonable time period, either the complaining party or the physician against whom formal written charges have been brought, may petition the Illinois State Medical Society Judicial Panel to request the District Ethical Relation Committee to intervene and take jurisdiction of the matter. In the event of a dispute resulting from such actions, the Judicial Panel shall determine, as provided in Part 7 of this chapter, the appropriate forum for the hearing.

Part 3. Offenses.

A. Disciplinary action may be taken against any member of a component society when:
 1. The physician has been convicted, adjudged or otherwise recorded as guilty by any court of competent jurisdiction of a felony or a crime involving moral turpitude; or
 2. He has been adjudged or otherwise recorded as guilty by his component society of:
 a. acts of serious misconduct as a physician; or
 b. a violation of the Constitution or Bylaws of his component society, or of the code of Medical Ethics promulgated by the Illinois State Medical Society; or
 3. He has been judged guilty of a violation of a law or regulation by an administrative agency of government resulting in the termination of his privileges, license, or other rights held by the physician.

Part 4. Standards and Procedures.

A. The committee, in its deliberations, shall evaluate acts by the standards established in the Constitution and Bylaws of the Illinois State Medical Society and/or the component medical society of which the accused is a member.

B. Disciplinary action may be initiated by the component society or the ISMS upon receipt of formal written charges filed by any person, alleging violations of any of the offenses enumerated in Part 3 of this chapter. The person filing the complaint may submit it to either the county where the accused physician holds membership or the county where the alleged incident occurred.

 Written charges received by the Illinois State Medical Society shall be referred to the secretary of the component society in which the accused physician maintains membership or practices medicine. The component society may then exercise the choice of proceeding through its own Ethical Relations Committee or referring the complaint to the District Ethical Relations Committee. Disciplinary action may also be initiated upon the filing of a complaint of an alleged violation of any of the listed offenses by a component medical society against a physician, such complaint having been filed by the secretary of the component society, on its behalf.

Part 5. Penalties. The component society's or District Ethical Relations Committee shall submit their recommendations for disciplinary action in writing to the component society. The recommendation shall be to: (a) acquit; (b) censure; (c) suspend; or (d) expel from membership.

The recommendation to censure shall mean an entry will be made in the accused physician's membership file to the effect that the

physician has been found guilty of the act complained of and that he has been properly advised of the finding. No deprivation of membership privileges will be imposed.

The recommendation to suspend shall mean that for a fixed period of time, to be determined by the component society, the accused physician shall forfeit his rights to vote and otherwise to participate in the affairs of the local, state and national societies. In all other respects, his membership shall remain intact.

The recommendation to expel shall mean that the membership status and privileges and rights attendant thereto of the accused physician shall be terminated for a period of one year. At the conclusion of the twelve (12) month period, the physician may re-apply for membership in the society; however, he shall then have the burden of demonstrating that the conditions and factors which contributed to this expulsion have since been removed and need not be considered in the process of reviewing his application for renewed membership.

Part 6. Decision by Component Medical Society.

A. The recommendations of the Ethical Relations Committee must be presented to the component society for approval, rejection, modification or reconsideration. The complainant and accused shall be given reasonable advance notice of the date set for the meeting when the committee's recommendations will be considered. The complainant and the accused each may submit a written statement of their respective positions to the component society. If either the complainant or the accused feels that errors were made during the proceeding before the Ethical Relations Committee or that new and additional relevant information has become available since the committee conducted its hearing, said party shall submit a description of these errors or new evidence to the component society prior to the component society's review. At the discretion of the component society, the complainant, the accused, and their legal counsel may appear before the society to testify.

B. If the component society believes that the new evidence not previously disclosed to the committee is relevant and material or that procedural error was committed, that component society may refer the matter back to the Ethical Relations Committee for reconsideration. The notice shall state the reasons for the referral and shall set a time limit within which a subsequent hearing must be conducted and recommendations must be presented to the component society.

Part 7. Judicial Panel. A Judicial Panel shall be created and empowered to conduct all appellate hearings arising out of Chapter XI of these bylaws and such other appellate proceedings as may derive from disputes or grievances among physicians practicing or residing in the State of Illinois. The panel shall render its decisions based on these hearings and related deliberations. The panel may, on request, adjudicate disputes among individual physicians or physician groups, between component medical societies and district Ethical Relations Committees, and between local medical societies and the Illinois State Medical Society when such disputes involve or impact the individual rights of physicians practicing or residing in this state; except that the Judicial Panel shall have the power on its own initiative to intervene when an Ethical Relations Committee of a component medical society fails to act in a timely manner, as provided in Part 2 of this chapter. The component medical societies and District Ethical Relations Committees shall cooperate with the Judicial Panel in the collection of statistical information for the purpose of identifying the manner in which due process of law is guaranteed to physicians accused of violations of provisions of these bylaws.

A notice of appeal shall be filed with the ISMS Judicial Panel by one of the parties within 30 days after receiving notice of a decision from the component society. Within 15 days after the required filing date for appeal, the party requesting the appeal shall file a written statement with the Judicial Panel which shall include a description of the errors believed to have occurred during the prior proceedings or assertations of the substantive grounds for requesting the Appellate Hearing.

A party may be granted an appeal hearing if: 1) There is reason to believe that procedural error(s) ocurred which significantly affected the outcome of the case; 2) There is a showing that those who conducted the initial hearing acted with bias; 3) The evidence upon which the decision was based was not sufficient to support the decision; 4) The evidence was not properly received or considered; or 5) In the sole discretion of the Judicial Panel, there were other reasons which adversely governed the proceedings and denied due process rights to the party requesting the appeal.

The decisions of the Judicial Panel shall be final; except that an appeal may be requested by the accused member under the Constitution and Bylaws of the American Medical Association. The Judicial Panel of the Illinois State Medical Society shall confine all decisions to its proper appellate function which is to sustain, remand or overturn a decision rendered or reduce a penalty imposed by a county society or district ethical relations committee.

Members of the Judicial Panel shall be elected by a majority of the members of the House of Delegates, upon nomination by the President of the Illinois State Medical Society. The panel shall consist of five active members of the Illinois State Medical Society, elected for five-year terms on a staggered basis; except, that of the members elected to fill the initial terms on the panel, one shall be elected for an initial one-year term, one shall be elected to an initial two-year term, one shall be elected to an initial three-year term, one shall be elected for an initial four-year term and one shall be elected to an initial five-year term. Those elected to serve as members of the initial panel may be re-elected to a second full five-year term; however, succeeding members of the panel may only serve one five-year term. Those members of the Judicial Panel elected at the interim meeting in November, 1978, would serve until the next appropriate meeting of the House of Delegates.

In the event a vacancy on the Judicial Panel occurs, the President of the Illinois State Medical Society shall nominate a successor who shall serve, if approved by the Board of Trustees, until the next meeting of the House of Delegates. At its meeting following such interim appointment, the House of Delegates shall elect a member of ISMS to fill the unexpired term on the Judicial Panel by the procedure described in these bylaws. In the event members of the Judicial Panel are unable to participate in an Appellate hearing for any reason, resulting in fewer than three members of the Panel ready and able to participate in a given appeal, the President shall recommend to the Executive Committee of the Board of Trustees and that committee shall appoint additional interim members to fill out the five-member Panel. These interim members shall serve only for the purpose of conducting and participating in the pending Appeal and their term as members of the Panel shall begin and end with the conduct of the Hearing assigned to them by the Executive Committee of the Board of Trustees. The members of the panel shall elect from among them a chairman who shall serve until his successor shall be elected by a majority of the members of the panel.

The panel shall meet as often as necessary in order to assure a reasonably prompt disposition of matters properly placed before it and shall convene on the call of the chairman. Three members of the panel shall constitute a quorum for the transaction of its business.

The panel shall adopt such rules as it deems appropriate for the orderly conduct of its duties. A written copy of such rules shall be made available to each component society and to the chairman of the Board of Trustees. The panel shall publish a *Handbook for the Conduct of Disciplinary Proceedings,* to be approved by the House of Delegates and which shall serve as a general guideline to all component medical societies in the conduct of hearings.

The chairman of the panel shall report to the House of Delegates at each of its annual meetings, thereby informing the members of the House of Delegates of the proceedings and deliberations of the panel during the preceding twelve months.

Part 8. Due Process Safeguards. In all proceedings conducted in accordance with the provisions of this chapter, the accused physician's rights to due process of law shall be honored and observed. The *Handbook for the Conduct of Disciplinary Proceedings* will set forth general guidelines for affording such due process protections.

CHAPTER XII PEER REVIEW

Part 1. Definitions. Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical Society peer review shall be conducted by the county society where the physician holds membership or where the incident which served as the basis for the peer review complaint occurred. Ethical relations issues identified during deliberations of the county peer review committee, or where appropriate, the District Peer Review Committee may be referred to either the county or district ethical relations committee, as deemed appropriate by the county (district) committee.

Should an adverse decision be made against a physician by a county society where the reviewed practitioner does not hold membership, that decision will have the weight and effect of a decision made by his own county society. Peer Review Committees should apply standards developed by appropriate physician organizations; such standards to be tempered by customs and practice followed in the local community in which the evaluation is undertaken. Decisions and recommendations of Peer Review Committees shall be advisory only.

Part 2. Component Society Procedures.

A. *Responsibilities*—Each component Society may have, either by appointment or election, a review committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients and, at local option, other parties. In the event a component Society shall choose not to appoint or elect its own review committee, the component Society may, by action of a majority of its members eligible to vote, delegate the peer review functions to an appropriate physician organization competent to perform these functions within the geographic area served by the component Society or to a District Peer Review Committee as provided for hereinafter. The District Peer Review Committee shall function and operate on behalf of any component Society which does not establish such a committee.

B. *Procedures*—The review committee of the component Society shall establish reasonable rules of procedure but shall not be bound by technical rules applied in courts of law or in administrative hearings conducted by governmental agencies. All complaints and inquiries shall be reduced to writing and shall be signed by the individual making the complaint or inquiry. Complaints received by the Illinois State Medical Society shall be referred to the proper component Society or District Committee.

C. *Timely Reviews*—The review committee of the component Society shall consider all complaints and inquiries properly filed with the Society in a timely manner and shall render its advice within a reasonable period of time following the receipt of a properly submitted complaint or inquiry. In the event the component Society shall fail to act in a timely fashion, as required in its rules of procedure, the party submitting the complaint or inquiry may petition the Peer Review Appeals Committee of the Illinois State Medical Society, as provided for hereinafter, to take jurisdiction of the complaint or inquiry.

D. *Appeals*—Such parties to the proceedings as delineated below, conducted by the component society may petition the Peer Review Appeals Committee of the Illinois State Medical Society to review certain local proceedings of the component society or district committee. A petition for an appeal must set forth one of the following grounds as a basis for the appeal:

1. PROCEDURAL ERROR—The peer review proceeding was not conducted in accordance with written rules established by the component society, district committee, or the Illinois State Medical Society.
2. BIAS—The proceeding was conducted in a biased or arbitrary manner.
3. INCOMPLETE INFORMATION—If information not available to the component society or district committee is submitted to the State Peer Review Appeals Committee, the committee will first determine the relevancy of the new information. The case will be referred to the component society or district committee for reconsideration if the information is deemed to be pertinent and significant by the State Committee.

A member of the Illinois State Medical Society, who is a party to a peer review proceeding and who has received a final determination from the component Society, may file an appeal with the State Peer Review Appeals Committee, in accordance with Section D, as stated above, as a matter of right. A patient who brings a complaint shall enjoy the privilege of petitioning the State Committee to review the decision of a component Society and the State Committee shall, in its sole discretion, determine whether or not to accept the case on appeal. No other parties shall enjoy the privilege to appeal a decision of the component Society.

In the event of an appeal to the Illinois State Medical Society, the component Society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the findings and recommendations of the component Society or District Committee. The right to appeal to the Illinois State Medical Society Peer Review Appeals Committee shall be limited to 30 days after the decision of the component Society or District Committee, unless the appellant can provide an acceptable reason for additional time.

Part 3. District Committee. The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Peer Review Committee to function in those instances when the component Society chooses to delegate to its District Peer Review Committee the responsibility to perform the review functions set forth in this Chapter. Upon completion of hearings of each complaint or inquiry referred to it by the component Society, the District Committee shall render its findings and recommendations to the component Society for affirmation. The District Peer Review Committee shall also consider complaints or inquiries assigned to it by the Illinois State Medical Society Peer Review Appeals Committee in those instances when it is determined by the State Committee that a component Society has failed to act in a timely fashion on a peer review complaint or inquiry submitted to it.

Part 4. Illinois State Medical Society Procedures.

A. There shall be created a Peer Review Appeals Committee, appointed by and reporting directly to the Board of Trustees. The Committee shall consist of seven members who shall serve one-year terms but, in no event, more than five consecutive one-year terms. Vacancies shall be filled by appointment by the Board.

The Peer Review Appeals Committee shall review appeals of decisions of component or district peer review committees in accordance with the provisions of Part 2 (D) of this chapter. The state committee shall determine the validity of the alleged grounds and, if found valid, remand the case to the local or district committee for a rehearing. If the alleged grounds are found invalid, the decision of the district or county committee shall be deemed to be reaffirmed. The decision of the Peer Review Appeals Committee shall be forwarded first to the county or district committee and then to the appellant. The state committee shall have authority to assign cases to district peer review committees in accordance with Part 3 of this chapter. Decisions of the state committee shall be final.

B. The State Peer Review Appeals Committee shall adopt appropriate rules for the conduct of its business and shall act on all appropriately filed appeals in a timely manner. The State Committee shall notify the appropriate component Society of its decision in a given case prior to its notification of the parties to the appeal.

C. If, in the judgment of the State Committee, a matter submitted to it on appeal is deemed to be more appropriately treated as an ethical relations issue, the Committee shall refer that case for disposition to the Judicial Panel, created under Chapter XI of these Bylaws.

CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be

acted upon before the day following that on which it was introduced.

CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

CHAPTER XVI. INDEMNIFICATION

Part 1. Third Party Actions. The Illinois State Medical Society ("Society") shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative, including all appeals (other than an action, suit or proceeding by or in the right of the Society) by reason of the fact that he is or was a director, trustee, officer, or employee of the Society, or is or was serving at the request of the Society as a director, trustee, officer, or employee of another corporation, partnership, joint venture, trust, or other enterprise, against expenses (including attorneys' fees), judgments, decrees, fines, penalties, and amounts paid in settlement actually and reasonably incurred by him in connection with such action, suit or proceeding if he acted in good faith and in a manner which he reasonably believed to be in or not opposed to the best interests of the Society and, with respect to any criminal action or proceeding, had no reasonable cause to believe his conduct was unlawful. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of *nolo contendere* or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which he reasonably believed to be in or not opposed to the best interests of the Society and, with respect to any criminal action or proceeding, had reasonable cause to believe that his conduct was unlawful.

Part 2. Derivative Actions. The Society shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action or suit, including all appeals, by or in the right of the Society to procure a judgment in its favor by reason of the fact that he is or was a director, trustee, officer, or employee of the Society, or is or was serving at the request of the Society as a director, trustee, officer, or employee of another corporation, partnership, joint venture, trust, or other enterprise, against expenses (including attorneys' fees) actually and reasonably incurred by him in connection with the defense or settlement of such action or suit if he acted in good faith and in a manner he reasonably believed to be in or not opposed to the best interests of the Society, except that no indemnification shall be made in respect of any claim, issue or matter as to which such person shall have been finally adjudged to be liable for negligence or misconduct in the performance of his duty to the Society unless and only to the extent that the court in which such action or suit was brought shall determine upon application that, despite the adjudication of liability but in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for such expenses as such court shall deem proper.

Part 3. Rights After Successful Defense. To the extent that a director, trustee, officer or employee has been successful on the merits or otherwise in defense of any action, suit or proceeding referred to in Section 1 or 2, or in defense of any claim, issue or matter therein, he shall be indemnified against expenses (including attorney's fees) actually and reasonably incurred by him in connection therewith.

Part 4. Other Determination of Rights. Except in a situation governed by Section 3, any indemnification under Section 1 or 2 (unless ordered by a court) shall be made by the Society only as authorized in the specific case upon a determination that indemnification of the director, trustee, officer, or employee is proper in the circumstances because he has met the applicable standard of conduct set forth in Section 1 or 2. Such determination shall be made (a) by a majority vote of trustees acting at a meeting at which a quorum consisting of trustees who were not parties to such action, suit or proceeding is present, or (b) if such a quorum is not obtainable (or even if obtainable), and a majority of disinterested trustees so directs, by independent legal counsel (compensated by the Society) in a written opinion, or (c) by the affirmative vote in person or by proxy of the membership entitled to vote in the election of trustees, without regard to voting power which may thereafter exist upon a default, failure, or other contingency.

Part 5. Advances of Expenses. Expenses of each person indemnified hereunder incurred in defending a civil, criminal, administrative, or investigative action, suit, or proceeding (including all appeals), or threat thereof, may be paid by the Society in advance of the final disposition of such action, suit, or proceeding as authorized by the Board of Trustees, whether a disinterested quorum exists or not, upon receipt of an undertaking by or on behalf of the director, trustee, officer, or employee, to repay such amount unless it shall ultimately be determined that he is entitled to be indemnified by the Society.

Part 6. Nonexclusiveness; Heirs. The indemnification provided by this Article shall not be deemed exclusive of any other rights to which those seeking indemnification may be entitled as a matter of law or under the Articles, the Regulations, any agreement, vote of the membership, any insurance purchased by the Society, or otherwise, both as to action in his official capacity and as to action in another capacity while holding such office, and shall continue as to a person who has ceased to be a director, trustee, officer, or employee and shall inure to the benefit of the heirs, executors, and administrators of such a person.

Part 7. Purchase of Insurance. The Society may purchase and maintain insurance on behalf of any person who is or was a director, officer, or employee of the Society, or is or was serving at the request of the Society as a director, trustee, officer, or employee of another corporation, partnership, joint venture, trust, or other enterprise against any liability asserted against him and incurred by him in any such capacity, or arising out of his status as such, whether or not the Society would have the power to indemnify him against such liability under the provisions of this Resolution or of the General Not For Profit Corporation Act.

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1988-1989

Policy Manual of the Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, AMA delegates and alternate delegates, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

(1) approve, amend, or reject—
(2) refer the statement to the Board for reconsideration and subsequent report—
(3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

Established policy must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

Professional Policies

Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Abortions must be performed in conformance with state and federal law and current medical standards, and when so performed shall not be considered unethical. Physicians shall not be required to perform or participate in an abortion by hospital regulations or any other institutional requirement.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Abuse of Persons—Children, Elderly

ISMS urges all state health agencies and family service agencies which become involved in child abuse cases, to conduct, promptly, necessary investigation of the family environment prior to the release of the child for return to the same home where the abuse occurred.

ISMS opposes abuse of children in Illinois schools.
(1981 Annual Meeting—Amended, 1987 Annual Meeting)

Physicians, nurses and other health care personnel are reminded to be aware of possible instances of abuse and neglect of the elderly and are encouraged to report suspected cases appropriately.
(1982 Annual Meeting—Reviewed by Board, 1987)

Acupuncture

Acupuncture is a surgical procedure and its practice shall be limited to physicians licensed to practice medicine in all of its

branches and to dentists.
(1975 Annual Meeting—Reviewed by Board, 1987)

Advertising Guidelines, Professional

See appendix for state law on physician advertising.
(Amended 1985 Annual Meeting)

Alcoholism/Substance Abuse

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity, by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational or social adjustments as a direct consequence of persistent and excessive use of alcohol. Insurance companies should include appropriate coverage for alcoholism. Physicians and their hospitals are encouraged to actively participate in providing services for alcoholics.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that physicians and recognized community service agencies should enlarge their services to include treatment and counseling of alcoholics and their families, and, where appropriate, collaborate with recognized alcohol treatment programs; that education programs aimed at alcohol abusers who are drivers should be encouraged, and legal restrictions should be continued to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects, as well as socioeconomic impacts, should be encouraged.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1987)

Ambulance Services

All ambulance services should meet minimum standards as established by appropriate authorities in the field. ISMS should offer its expertise and work to ensure that ambulance services meet these standards.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Anaphylactic Reactions to Insect Stings

ISMS favors development of mechanisms to allow the availability of epinephrine, through appropriately trained persons, upon the prescription of a physician.
(1981 Annual Meeting—Reviewed by Board, 1986)

Animals in Research and Education

The Illinois State Medical Society endorses the position that research and medical education, which involves the use of animals, is necessary to enhance the medical care of the public.
(1983 Annual Meeting)

Assessments

Medical staffs are reminded that hospitals do not have the privilege or the right to make compulsory assessments on individual members of the medical staff for building funds or other hospital programs, nor to demand an audit of staff members' personal financial records as a requisite for staff appointments.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Athletic Performance, Inappropriate Use of Procedures to Improve

The Illinois State Medical Society opposes the use of such items as, but not limited to, hormones, drugs and blood transfusions solely to improve athletic performance.
(1985 Annual Meeting)

Athletic Programs

The medical profession should provide input into the structuring of athletic programs in an effort to minimize physical injuries and inappropriate emotional stress and to insure proper treatment.
(Amended 1980 Interim Meeting—Reviewed by Board, 1987)

Audits and Surveys

ISMS recognizes the necessity of audits and surveys to review the appropriateness of medical services rendered. However, respect for personal privacy and confidentiality must be maintained with utmost priority under all circumstances. Additional, local medical staff audits and determinations as to management must be respected. In this regard, ISMS recognizes audit processes as performed by organizations who have demonstrated compliance with the aforementioned principles. In contrast, audits and surveys not performed by recognized organizations, or those performed in violation of the above principles, will not be condoned.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1987)

Autopsies

Because the autopsy has public health and educational benefits for medical science, the family of the deceased individual and the public at large, ISMS encourages its members to seek family approval for the postmortem examination in all cases of death.
(Amended, 1984 Annual Meeting)

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.
(1971 Annual Meeting—Reviewed by Board, 1986)

Blood Availability

Since the use of a replacement or penalty fee has been eliminated in this state, ISMS encourages component societies to promote the public's full acceptance of the concept of truly altruistic blood donation and community responsibility.

The Illinois State Medical Society and its component societies should strongly encourage hospitals and any other facilities to affiliate with a regional blood replacement center in their areas.

The Illinois State Medical Society and its component societies should assist appropriate organizations in establishing a regionally coordinated blood banking system throughout the state and areas contiguous to the state.
(Amended, 1985 Annual Meeting—Reviewed by Board, 1987)

Blood Services

Inasmuch as blood services affect the entire community, the county medical society should be encouraged to become involved and should have input in blood bank activities serving its county.

The Illinois State Medical Society will attempt to educate physicians and their patients through its publications regarding the inability of contracting AIDS by donated blood. "Designated blood donations" are an inappropriate means of dealing with the AIDS problem and inordinately tie up blood supplies.
(Amended, 1984 Annual Meeting—Reviewed by Board, 1987)

Breast Cancer Screening

The Illinois State Medical Society Supports the American Cancer Society guidelines for breast cancer screening as a means to identify and treat early stage breast cancers.
(1986 Annual Meeting)

Cardiopulmonary Resuscitation

ISMS encourages basic cardiac life support training in Illinois high schools.
(1981 Annual Meeting—Reviewed by Board, 1986)

CPR and First Aid Training for Health Club Employees, Mandatory

ISMS endorses the concept that persons responsible for monitoring or instructing others in health and fitness facilities be certified in basic cardiopulmonary resuscitation.
(1984 Annual Meeting)

Child Safety Restraints

ISMS supports and encourages public education and legislation promoting child safety restraint use (infant and toddler car seats) and encourages physicians and others to discuss their benefits with all parents. Physicians are encouraged to learn about important safety features which have proven effective.
(1981 Interim Meeting—Reviewed by Board, 1986)

Chronic Care Patients

The Illinois State Medical Society encourages medical schools and residency training programs to develop curricula addressing the issues of utilization of community resources and the strategies for dealing with the long-term medical, rehabilitation and social needs of chronic care patients.
(1984 Annual Meeting)

Code of Ethics

The following Code of Ethics represents standards of conduct defining the essentials of honorable behavior for the physician. They are not laws.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

(1981 Interim Meeting—Reviewed by Board, 1986)

Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileged communication must be continued in accomplishment of the treatment of human illness.

Section IV of the ISMS Code of Medical Ethics states that: "A physician shall respect the rights of patients . . . and shall safeguard patient confidences within the constraints of the law."

The Illinois State Medical Society reaffirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept that access to individual identifiable employee medical records by employers or government agencies, except as required by law, is contrary to traditional and legal medical practice, in conflict with the patients' best interest, and inimical to public policy.
(Amended, 1988 Annual Meeting)

Confidentiality and Utilization Review

In order to protect patient care and confidentiality, all requests for patient information should be accompanied by appropriate authorization and appropriate releases. Physicians in Illinois should use considered judgment when discussing any patient's care over the telephone.

The Illinois State Medical Society objects to utilization review performed solely upon the basis of admitting diagnosis without actual hospital record review as being inadequate, incomplete and incapable of accuracy.

Physicians in Illinois who receive patient permission for a case discussion by telephone from their patients on behalf of third party payors may, ethically and in their own best judgment, make a determination as to whether a reasonable charge for their time and expertise in providing such telephone case review discussions should be made, if any, for these medical services.
(Amended, 1988 Annual Meeting)

Continuing Education

The Illinois State Medical Society shall continue its strong support of voluntary continuing medical education in Illinois and the intrastate accreditation of quality CME programs. Continuing education is one of the basic functions of the Illinois State Medical Society, which is committed to scientific advancement, humanization of medicine, and development of cooperation and rapport with the public.

ISMS will act as an accrediting agency under the policies of the Accreditation Council for Continuing Medical Education as established by the organizations comprising the Council for Medical Affairs. The Illinois State Medical Society should have a primary role in accrediting of quality continuing medical education programs in order to assure that members have access to CME opportunities.

Physicians are encouraged to analyze their individual learning needs before registering for CME courses.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

Sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses. Accrediting body and category of credit should be stated.
(Amended, 1986 Annual Meeting)

Cost Containment

ISMS endorses the Voluntary Effort of American physicians and hospitals as responsible private sector activity to restrain hospital costs without arbitrary limits or governmental intervention, and it endorses the AMA president's call for physicians to help moderate care costs.

ISMS supports the concept of voluntary planning. ISMS should continue monitoring of planning legislation as to costs, benefits, and effectiveness; and encourage establishment of equitable techniques for administration of federal requirements. ISMS opposes imposition of the public utility type of regulation of the medical profession, whether institutional providers or private physicians. Certificate of need, as a cost containment mechanism, is a nonproven concept and requires continued evaluation.

"Decertification" or conversion to other use of excessive facilities should be on a voluntary and trial basis before final implementation.

The development of appropriate policies and mechanisms that lead to continuity, coordination, and continuous availability of patient care, including appropriate professional preventive care and appropriate early-detection screening services, should be encouraged. The appropriateness of a service, test or treatment should be the primary factor in considering its necessity rather than the cost.

Regulatory systems to certify and monitor the performance of insurance carriers, mutual insurance companies and other organizations financing health care services should be established to assure fiscal responsibility and accurate representation of premium or capitation costs and benefits that will not restrict development of innovative approaches to benefit coverage.
(Amended, 1983 Annual Meeting)

Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians.
(1977 Annual Meeting—Reviewed by Board, 1986)

Death, Legal Definition of

A determination of death is a medical diagnosis which must be made in accordance with accepted medical standards by a physician licensed to practice medicine in all its branches, which may be made when an individual has sustained either: (1) Irreversible cessation of circulatory and respiratory functions, or (2) Irreversible cessation of all functions of the entire brain, including the brain stem.
(Amended, 1981 Interim Meeting—Reviewed by Board, 1986)

Diagnosis Related Groups

ISMS supports the concept that the individual hospital medical staffs' responsibility is to ensure that appropriate quality of care for patients shall not be compromised in the Diagnosis Related Groups (DRG) process.
(1983 Annual Meeting)

DRG Payments and Cost of Procedures

ISMS encourages hospitals to establish a mechanism whereby physicians will have ready access, upon admission of patients, to information about expected DRG payments and charges for hospital procedures.
(1984 Annual Meeting)

Disaster Control

All medical societies should cooperate with and contribute to disaster plans in their communities.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Discrimination Against Physicians

The quality of medical training is an appropriate concern in the recruiting and credentialing of physicians. However, it is inappropriate to discriminate against any physician because of national origin or geographic location of medical education.
(1985 Annual Meeting—Reviewed by House, 1988)

Drinking Age, Legal

A uniform national legal drinking age of 21 years should be established by all states.
(1984 Annual Meeting)

Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Only those generic drugs which are actually bio-equivalent should be included in the Illinois Formulary for the Drug Product Selection Program of the Illinois Department of Public Health.

ISMS urges IDPH to monitor and enforce proper generic drug substitution by pharmacists according to bio-equivalency based on the formulary.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.
(Amended, 1982 Annual Meeting)

Drunk Drivers

ISMS supports laws providing for stiffer sentencing of drunk drivers and encourages the judiciary to recommend rehabilitative treatment as an additional means of dealing with people convicted of driving while under the influence of alcohol.
(1981 Interim Meeting—Reviewed by Board, 1986)

Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.
(1976 Annual Meeting—Reviewed by Board, 1986)

Emergency Medical Care, Provision of

Emergency care should be provided to all patients, based only on medical necessity. Physicians should be aware of the protection afforded them by the Good Samaritan provisions of the Illinois Medical Practice Act.

All EMS systems should develop protocols which provide for cooperation between a physician on the scene of an emergency and paramedics responding to the emergency call. It is the obligation of the physician who happens upon the scene of a medical emergency to provide reasonable identification to paramedic personnel that he/she is a physician and, if appropriate, has training in emergency procedures. If the paramedics are not in uniform, they should provide identification to the physician that they are certified by the state to provide emergency medical care. When paramedics are present, a physician should avoid involvement in resuscitation measures that exceed his or her prior training or experience. Where voice communication with the medical control facility is available, the paramedics and the physician on the scene should interact with the local medical control authority. Where voice communication is not available, the physician on the scene of an emergency should cooperate with and abide by the EMS protocols, and permit the paramedic team to function within their guidelines and the EMS law. In a nonemergency situation, where the EMS system provides the only available ambulance service in an area, a private physician and the medical director of the EMS system should make every effort to cooperate in the treatment and transportation of the patient, either through written protocols or voice contact, prior to requesting the ambulance service.

The Illinois State Medical Society encourages the State of Illinois and the business community to provide an emergency medical kit and qualified individuals for the administration of appropriate emergency care at functions where a very large number of individuals are present.

Insurance plans which cover emergency medical services should pay for such services regardless of where they are rendered.
(Amended, 1987 Annual Meeting)

Experimental Medical Procedures

With respect to experimental medical procedures, physicians must adhere to and affirm the following:

- Accepted ethical standards;
- The codified regulations of the Department of Health and Human Services as specified in Title 45 USC, Sec. 46;
- Appropriate Illinois statutory or regulatory requirements.

(Amended, 1981 Annual Meeting—Reviewed by Board, 1986)

Eye Care

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or administer eye medication for therapeutic purposes and services. ISMS vigorously opposes any legislative attempt in Illinois to allow non-physicians to prescribe or use medications other than approved topical agents used for diagnosis.
(Amended, 1987 Annual Meeting)

Fees, Informing Patients of

Where feasible and desirable, physicians should provide patients with information regarding fees and, where practicable, discuss this information prior to providing care.
(1984 Annual Meeting)

55 M.P.H. Speed Limit

The Illinois State Medical Society opposes an increase in the 55 mile per hour speed limit.
(1981 Annual Meeting—Reviewed by Board, 1986)

Firearms

The Illinois State Medical Society supports the right of counties or municipalities to enact ordinances restricting the ownership, possession, purchase, sale, transport or transfer of firearms or firearm ammunition. It opposes any state legislation in Illinois that would prohibit the enactment or enforcement of county or municipal ordinances restricting the ownership, purchase, sale, transport or transfer of firearms or firearm ammunition.
(1982 Annual Meeting—Reviewed by Board, 1987)

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.
(Amended, 1986 Annual Meeting)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees.

The Illinois State Medical Society encourages cost sharing by patients in all medical care reimbursement plans.
(1977 Interim Meeting—Reviewed by Board, 1986)

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.
(1967 Annual Meeting—Reviewed by Board, 1986)

Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which quality of care is compromised.

It is opposed to national compulsory catastrophic health insurance.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured as long as the plan has a demonstrated physician-supported patient care management program in effect.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs for limited license practitioners without direct supervision and responsibility for patient care by a physician licensed to practice medicine in all its branches in Illinois.
(Amended, 1986 Annual Meeting)

Health Insurance, Voluntary Plans

ISMS supports private, voluntary catastrophic health insurance, including freedom of choice of physician. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

The Illinois State Medical Society supports the concept of increased insurance coverage for ambulatory diagnostic tests.

It supports the policy of a tax credit or deduction for the premium expense of catastrophic medical insurance and endorses the principle that, under federal rules and regulations, the costs and premiums for health care, whether incurred directly by an individual or conferred as an employee benefit, should be equally deductible.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

When insurance benefits are assigned to a physician by a patient, care should be exercised by the insurance company, or its agent, in seeing that such wishes of a patient are followed. If an error is made by the insurance company, or its agent, and payment is made to the patient, the insurance company is urged to admit its error and pay the physician as it was originally directed to do. Under such circumstances, recouping of the money from the patient should be the responsibility of the insurance company, or its agent, that committed the error and not the responsibility of the physician.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

- Implying to patients that physicians' charges above insurance benefit allowances are excessive;
- Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;
- Suggesting that physicians perform alternative surgical procedures;
- Instituting utilization review of hospital patients in the private sector which by-passes local physician review mechanisms;
- Discriminating against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

ISMS endorses long-held principles that:

- A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and
- The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

(Amended, 1982 Annual Meeting)

Health Maintenance Organizations

Every insurance identification card for a health maintenance organization should have the designation, "HMO" clearly printed on the front of the insurance card, along with the warning that unauthorized services may not be reimbursed and along with a 24-hour telephone number which can be called for payment approval in the event of an emergency.
(1982 Interim Meeting—Reviewed by Board, 1987)

Health Planning

ISMS supports health planning on a local and voluntary basis with input by a significant number of physicians licensed to practice medicine in all its branches. Planning and implementation of the plan (regulation) are two different processes and should be kept separate and distinct. ISMS opposes the imposition of the public utility type of regulation of the medical profession. The concept of certificate of need requires continued evaluation.
(Amended, 1987 Annual Meeting)

Health Screening by Allied Health Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.
(1974 Annual Meeting—Reviewed by Board, 1986)

Health Systems Agencies

The Illinois State Medical Society supports legislative activity by the American Medical Association repealing the Federal Health Planning Act, Public Law 93-641 and Public Law 96-79 as amended. As an interim measure, ISMS will seek legislative amendment in Congress or an administrative exemption removing those portions of the Health Planning Act which impose penalties on states not in compliance with federal SHPDA designated criteria.
(1981 Annual Meeting—Reviewed by Board, 1986)

HSA Fund Solicitation

The Illinois State Medical Society is opposed to outside fund solicitation by Health Systems Agencies; for such practices may affect the objectivity of the organization.
(1980 Annual Meeting—Reviewed by Board, 1986)

Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.
(1977 Annual Meeting—Reviewed by Board, 1984)

Hospices

A hospice is a centrally administered program of palliative and supportive services providing medical, social, psychological and spiritual care for terminally ill persons and their families. Services are provided by a medically-supervised, interdisciplinary team of professionals and volunteers. Care is offered 24 hours a day, 7 days a week,

through either in-patient settings, home care or a combination of both. Bereavement counseling is provided for the survivors.
(1981 Annual Meeting—Reviewed by Board, 1986)

Hospital and Medical Staff Committees

A hospital's medical staff should be an autonomous, self-governing body whose members participate in the activities of medical staff and hospital committees. However, physicians should distinguish between committees over which the hospital gives the staff authority and responsibility and those over which the hospital has full responsibility. Medical staff committees should be those composed solely of members of the medical staff and concerned with the quality of medical care. Hospital committees should be viewed as those created for some general hospital function and composed mainly of hospital personnel, which may or may not include medical staff members.
(1982 Interim Meeting—Reviewed by Board, 1987)

Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. The hospital medical staff and only the medical staff should establish minimum limits of professional liability insurance coverage for their own medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on the medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of the hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Results of recertification examinations should not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges.

ISMS recognizes it is the right and duty of 1) a medical staff organization to evaluate the credentials of all applicants for medical staff privileges, according to objective, predetermined criteria of acceptability and 2) the hospital governing body to grant privileges to those applicants found acceptable and desirable as members of the medical staff.
(Amended, 1985 Annual Meeting)

Hospital Medical Staff Privileges

Members of a medical staff should receive due process as spelled out by the bylaws of the medical staff before their medical staff privileges can be terminated. The Illinois State Medical Society shall support physicians in their right to continue to practice in a community or hospital as long as they follow the bylaws of the medical staff and maintain the highest quality of medical practice to their patients unless good cause can be shown that continuation of the physician in practice is not in the best interest of his/her patients.

A physician's hospital privileges should be based on clinical competency and quality of care.
(Amended, 1985 Annual Meeting)

House Actions—Legal Procedures

The following procedure should be followed for review of House actions prior to publication or implementation:

- ISMS legal counsel should review all adopted resolutions for the purpose of assuring propriety, compliance with law, and protection of the profession.
- That, based upon ISMS legal counsel opinion and advice that an adopted resolution may be illegal or inimical to the profession, upon consultation between legal counsel, the Speaker of the House, the Chairman of the Board of Trustees and the President, an action may be deferred from publication or implementation upon approval by the Board of Trustees.
- If deferral of publication or implementation of an action by the House of Delegates is accomplished by the Board of Trustees, the Chairman of the Board of Trustees shall present a full and complete report to the next session of the House of Delegates, recommending recision or amendment of the item which was deferred.
 (1982 Annual Meeting)

IDPA Drug Manual

ISMS approves the concept that pharmaceutical products for inclusion in the IDPA Drug Manual be based on therapeutic effectiveness rather than cost. While ISMS members will continue to be cost conscious in all aspects of medical care, this care must be based upon therapeutic considerations and bioequivalence.
(1981 Annual Meeting—Reviewed by Board, 1986)

Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection or to encourage the local public health agency to perform this function, and to encourage enforcement of current immunization laws. In addition, physicians should be encouraged to participate in epidemiological studies (especially as related to "search and destroy" methods for communicable diseases) which have been endorsed by the local or state medical society.

ISMS continues to support the need for physical examinations of, and updating of immunizations for school children in the State of Illinois on school entry, at 5th grade and 9th grade levels, in keeping with preventive medicine measures presently in existence in the state. Measures to assure compliance of the school health mandates by school districts in Illinois should be maintained.

Every school district should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.
(Amended, 1984 Annual Meeting)

Impaired Physicians

The Illinois State Medical Society and its individial members should recognize the importance and need to promote, support and participate in state, local and hospital activities to prevent, recognize and overcome impairment among medical students, residents and practicing physicians.
(1985 Annual Meeting)

Indemnification

Physicians who serve state or local agencies as volunteers, independent contractors or employees, should be provided legal defense, indemnification and appropriate immunity by the governmental agency.
(1987 Annual Meeting)

Indigent, Care of the

The Illinois State Medical Society reaffirms organized medicine's commitment to provide care to those who need medical care, regardless of their ability to pay for it.

However, personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the

local level with local administration and control. The principle of freedom of choice should be preserved.
(Amended, 1982 Interim Meeting—Reviewed by Board, 1987)

Infants Born with Disabilities, Care and Treatment of

The Illinois State Medical Society urges all Illinois medical staffs to develop and conduct educational programs for their members involved in the care of handicapped infants, regarding advances in such care, as well as laws and regulations affecting the delivery of these infants.
(1984 Annual Meeting)

Informed Consent

ISMS endorses the position that disclosures made to patients conform to the general practices of the medical profession in the same or a similar community or locality, which are disclosures that a reasonable medical practitioner would make under the same or similar circumstances.

ISMS opposes legislative definition of informed consent.

However, it favors enactment of legislation providing that consent for furnishing medical treatment to an adult patient, who is not capable of consenting, may be given or refused by the patient's competent spouse, parent, adult child or adult sibling.
(Amended, 1982 Interim Meeting—Reviewed by Board, 1987)

Insanity as a Defense

ISMS supports the concept that a person may be found innocent of a crime by reason of having severe mental illness or retardation.

For a person to use insantiy as a defense, the severity of the person's mental condition should be shown to exhibit an inability to know the nature of his conduct at the time of the offense, and that he was unaware that the act was wrong and personally or socially destructive to himself or someone else.

Testimony by medical experts on the nature of a person's mental condition should be limited to the diagnosis, mental state and motivation of an individual and not on whether the person is "sane" as determined by legal standards.

A person found innocent by reason of insanity should be provided treatment and ongoing supervision to ensure the public is protected, and when psychiatric treatment can no longer help an individual, who is still considered dangerous, that person should be transferred to a nonmedical facility for further supervision.
(1985 Annual Meeting)

Joint Commission on Accreditation of Healthcare Organizations

A "physician" (doctors of medicine or doctors of osteopathy) is defined as one who by education, training, experience, and licensure is able to practice medicine in all of its branches.

ISMS opposes the development of any JCAHO Standard mandating medical staff membership to anyone other than physicians. ISMS encourages the Joint Commission on Accreditation of Healthcare Organizations to require greater than a majority of fully licensed physician membership on the medical staff executive committees in acute care general hospitals. ISMS urges JCAHO to recognize the importance of the medical staff in credentialing and in monitoring the quality of care in the hospital and it encourages the development of the appropriate environment within the hospital so that both the medical staff and limited licensed practitioners may work together for the best interests of the patient.
(1983 Annual Meeting—Amended 1987 Annual Meeting)

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician currently licensed to practice medicine in all its branches.

The Illinois State Medical Society opposes any attempt to change the Illinois Clinical Laboratory Act by exempting commercial laboratories or free-standing laboratories and clinics operated by hospitals from meeting the standards of this act.
(Amended, 1985 Annual Meeting)

Laboratory Inspections

Hospital and private independent clinical laboratories that are currently certified by and meet the standards of the College of American Pathologists' Inspection and Accreditation Program should be considered to have deemed status by the Illinois Department of Public Health and not be required to undergo unnecessary, duplicative annual licensure inspections.
(1988 Annual Meeting)

Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physician's judgment as to which procedures are appropriate and in the best interests of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.
(1974 Annual Meeting—Reviewed by Board, 1987)

Manipulative Casting of Congenital Deformities of the Extremities

Manipulative casting of congenital deformities of the extremities, whether performed in the office or hospital, is considered a surgical procedure.
(1981 Annual Meeting—Reviewed by Board, 1986)

Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.
(1976 Annual Meeting—Reviewed by Board, 1986)

Medical Diagnosis and Treatment

While the Illinois State Medical Society recognizes the interests of third parties in patient care, it categorically maintains that prognosis and length of treatment must always be individualized to the patient, the diagnosis, and community standards for medical care.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Medical Education—Schools

The Illinois State Medical Society supports development of innovative programs in medical education maintaining a firm foundation in the basic sciences.

It favors admission of students into medical schools on the basis of their ability to be good medical students and physicians.

It supports the philosophy that all medical education accepted for licensure to practice should be comparable.

Graduates of state medical schools are encouraged to practice medicine in Illinois and ISMS will utilize its organizational structure to develop positive incentives.

ISMS encourages primary care residency programs to establish educational activities in the rural and underserved areas of Illinois.
(Amended, 1982 Interim Meeting)

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coroner system, wherever practical.
(1971 Annual Meeting—Reviewed by Board, 1986)

Medical Liability Insurance Premiums

The Illinois State Medical Society supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category.
(1979 Annual Meeting—Reviewed by Board, 1987)

Medical Psychotherapy

Medical psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and nonverbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Medical Representation in Government Planning

Unless physicians appointed to the boards and committees of other organizations are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.

ISMS supports the concept that when federal funds are available to the states, representative physicians should actively participate in the distribution of these funds.
(Amended, 1982 Interim Meeting—Reviewed by Board, 1987)

Medical Staff Participation in Accreditation Activities

Medical staff of a hospital should cooperate to achieve JCAHO accreditation of their hospital.
(1982 Interim Meeting—Reviewed by Board, 1987)

Medical Staff Participation in Hospital Cost Containment Efforts

Physicians on a hospital's medical staff should encourage and cooperate in efforts to see that hospital care is delivered in the most effective manner without compromising quality.
(1982 Interim Meeting—Reviewed by Board, 1987)

Medical Staff Relationship with County Medical Society

County medical societies are encouraged to form standing committees composed of medical society officers and representatives of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations and official and voluntary health related agencies in their community.
(1982 Interim Meeting)

Medical Supplies, In-Flight

The Illinois State Medical Society encourages air carriers to equip planes with an emergency kit on each flight and that flight crews be instructed in cardiopulmonary resuscitation procedures.
(1982 Interim Meeting—Reviewed by Board, 1987)

Medical Testimony, Expert Witnesses

An expert witness is defined as a physician licensed to practice medicine in all its branches, having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, relevant personal experience, practical familiarity and technical knowledge of the problems that are being considered, as well as knowledge of alternative forms of treatment, and was active in the practice of the medical subject under discussion at the time the incident occurred.
(Amended, 1987 Annual Meeting)

Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to the judiciary. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Medicare Assignments

The Illinois State Medical Society supports the concept that Medicare payments be made directly to physicians who choose to accept Medicare assignments. When a Medicare payment is incorrectly made directly to the patient, Medicare should make full payment to the physician who has chosen to accept Medicare assignments as soon as the error is verified.
(1980 Interim Meeting—Reviewed by Board, 1986)

Mental Health

A. The Importance of Mental Health Education and Services:

ISMS recognizes the importance of mental health in the quality of a person's life and the devastating impact mental illness can have for an individual and one's family. Knowing that modern medicine has much to offer, ISMS supports the training of physicians in mental health care, the education of the public in recognizing mental illness and the development of private and public services for care.

B. The Physician's Role in Mental Health Services:

ISMS recognizes the primacy of the physician in the diagnosis and treatment of mental illness. Involuntary psychiatric hospital certification of any patient must, without exception, involve a physician licensed to practice medicine in all its branches. However, the discharge of any patient from a psychiatric institution must remain the responsibility of a physician.

C. Continuing Medical Education for Department of Mental Health and Developmental Disabilities Physicians:

The Department of Mental Health and Developmental Disabilities (DMHDD) should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

D. Cooperation between County Medical Societies and DMHDD:

Each constituent county society should cooperate fully with and support local units of the DMHDD in their patient care efforts, specifically seeking to encourage:
(1) Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle; (2) Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature; (3) Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician time available; (4) Arrangements for emergency mental health care, *i.e.*, crisis intervention, to be available areawide.

E. Patient Visits:

The number of times a patient is seen should not be the sole criterion of the necessity or adequacy of psychiatric care. The level of care needed by the patient must be a major factor in determining the delivery of that care. Each hospital or hospital system should establish its own standard of psychiatric care to include the level of care needed by that patient, and should monitor the adequacy of psychiatric care by means other than frequency of visits.

F. Community Mental Health Services:

ISMS supports and encourages the development of community options for services to the chronically mentally ill in the private and public sectors, although the Society opposes using such alternatives to inappropriately discharge these persons to inadequate services and living conditions, thereby increasing the number of homeless mentally ill.
(Amended, 1987 Annual Meeting)

Motorcycle Helmets

All Illinois physicians should encourage their patients who use motorcycles to wear protective helmets, pointing out the efficacy of such helmets in preventing death during collisions.
(1982 Annual Meeting)

Multiphasic Screening

Multiphasic screening tests (including brief physical examination and multiple automated laboratory tests) are accepted procedures for health evaluation when carried out in a scientific manner and in conformance with laws of the State of Illinois and regulations of the Department of Public Health. The persons participating in or sponsoring these activities should be advised that: (1) Abnormal findings do not necessarily indicate a disease exists; such a determination must be made by a physician; (2) The absence of abnormal findings does not necessarily indicate the patient is free of disease;

and (3) That such screenings should be done under the guidance of local medical societies or other recognized medical authorities.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1986)

Newborns, Prenatal Development of

The public concern about the macroenvironment's effects on human health should be expanded to include equal concern for a healthy intrauterine environment for the prenatal period of development of each child.
(1984 Annual Meeting)

Nurses—Shortage

The ISMS supports nursing education at all its levels.
(Amended, 1986 Annual Meeting)

Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician. .
(1973 Annual Meeting—Reviewed by Board, 1986)

Nutrition

Proper attention to patients' complete nutritional status should be of concern to all physicians. Patient education in the field of nutrition should be a major priority.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Occupational Health

Occupational health is an essential ingredient of employee welfare. The continued adoption and development of occupational health programs in the private and public sectors should be encouraged.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1986)

Optometric Services

ISMS supports the concept that those performing optometric services in Veterans Administration facilities should be directly responsible to their respective departments of ophthalmology.
(1978 Annual Meeting—Reviewed by Board, 1984)

Patient Care Records and Their Availability

Patient care records contain privileged information of confidential nature. Such records are the property of the hospital, clinic or physician. Information contained therein is held in trust by the holder.

In the case of hospital records, patients, patients' attorneys or patients' succeeding physician, upon written patient authorization, have the right of access to hospital records, the ability to review and the right to copy or receive copies. Hospitalized patients may be afforded access to their records upon discharge but not during hospitalization. This access is not afforded in case of psychiatric illness. In the case of nonhospital records, patients' attorney or succeeding physician, but not patients themselves, upon presentation of written patient authorization, have the right of access to said records, with the ability to review and the right to copy and receive copies.

Upon receipt of proper, written authorization from the patient, a copy abstract or summary shall be provided, as required, to legally authorized recipients of such record.

Patient records are utilized by official committees of organized medical staffs to accomplish scientific review, peer review or other patient care improvement. Reports and proceedings of such committees are confidential and shall not be disclosed to any person outside the purview of such committees. ISMS will take all appropriate action to preserve the confidentiality of records and activities of medical staff committees.

Pursuant to a subpoena for records, a physician is legally required to release medical records in the absence of a signed patient authorization. It is recommended that when records are released, a copy be maintained in the physician's file.

A reasonable charge for record copying service may be made.

Reference may be made 1979, Illinois Revised Statutes, Chapter 48, Section 138.8; Chapter 51, Sections 71, 73 and 101; Chapter 91½, Section 800ff.
(Amended, 1984 Annual Meeting)

Patient Discharge

A physician is under no obligation to discharge hospital patients prematurely and only a patient's physician is entitled to authorize discharge.
(1986 Annual Meeting—Reviewed by BOT 1987)

Patient Restraints

The use of restraints, especially in long-term care facilities should be permitted only when medically indicated and approved by the patient's attending physician.
(1988 Annual Meeting)

Peer Review

See Chapter XII of the Bylaws.
(Amended, 1983 Annual Meeting)

The Illinois State Medical Society is opposed to review which is not conducted by one's peers. A "peer" is a currently licensed physician, licensed to practice medicine in all its branches, who is experienced in the medical question under consideration and, whenever possible, whose primary practice is in the community involved. The ISMS is opposed to utilization review conducted entirely by telephone or similar communications, with no recourse to review by a physician in the same region of the state, whose practice is in the same specialty.
(1986 Annual Meeting)

Physician-Patient Relationship

The Illinois State Medical Society encourages voluntary health organizations to work with the available local medical communities in providing referral and treatment of cancer patients so that existing physician-patient relationships are not breached.
(1984 Annual Meeting)

Physician Records, Privacy of

The Illinois State Medical Society will take appropriate action to assure that no third party be granted access to the physician's own private medical practice business records, including copies of cancelled checks, cash disbursement journal, leases, contracts, or other confidential business records, without appropriate authority assuring due process.
(Amended, 1984 Annual Meeting)

Physicians

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches."
(Amended, 1982 Interim Meeting—Reviewed by Board, 1987)

Physician's Assistants

The Illinois State Medical Society recognizes the physician's assistant as a trained health professional who can serve a proper function within the scope of his/her certification and under the direct one-to-one supervision of a physician.
(1980 Annual Meeting—Reviewed by Board, 1986)

Professional Associations

It is ethical for physicians to associate professionally with whom they wish, acknowledging always that there is no compromise on the historically noble goals of honesty, competence, compassion, respect for dignity, furtherance of knowledge, safeguarding of confidence and service to mankind, and with due regard to modern medical science.
(1979 Interim Meeting—Reviewed by Board, 1986)

Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians, including the right of individual physicians to appear before appropriate peer review committees responsible for this liability coverage.
(Amended, 1978 Interim Meeting—Reviewed by Board, 1987)

Prolonging Human Life

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.

(1976 Annual Meeting—Reviewed by Board, 1984)

Provider Organizations, Exclusive

ISMS should monitor the development of health maintenance organizations, IPAs, preferred provider organizations, and exclusive provider organizations in Illinois and have this information available to assist ISMS members in their relationships with these organizations.
(1984 Annual Meeting)

Psychosurgery

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.
(1975 Annual Meeting—Reviewed by Board, 1986)

Public Aid

The fees paid by state/federal programs to physicians should be based upon the usual and customary fee concept.

Because modern medical care frequently requires multispecialty medical management, including primary care physicians and specialists working together for the benefit of the patient, traditional fees for multispecialty care for Public Aid patients should be made available without extensive justification procedures.
(Amended, 1986 Annual Meeting)

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and, if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

ISMS encourages and supports the development of local joint committees of county medical societies and county public health departments to review current and proposed public health projects.

ISMS encourages local health departments and component medical societies to delineate the roles of the public and private sectors in providing health and medical services to the community. The following should be considered: 1) coordination and facilitation of direct services which should occur in a manner to avoid duplication of available medical services; 2) the availability of private medical services; 3) the gaps in medical and health services that should be filled by public health activities; and 4) the socio-economic characteristics of the population to be served.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1986)

Rehabilitation

All physical rehabilitation activites should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.
(Prior to 1965—Reviewed by Board, 1986)

Reimbursement of Ambulatory Services

Third party payors should be encouraged to provide coverage for ambulatory surgery and diagnostic procedures. Final medical decisions must remain in the hands of the attending physician. However, the Illinois State Medical Society supports the concept of maximum utilization of ambulatory surgical services consistent with the doctor's judgment of the facilities available.
(Amended, 1982 Annual Meeting—Reviewed by Board, 1987)

Reimbursement for Medical Care of Psychiatric Illness

Medical care of psychiatric illness should be included in all health insurance policies.
(1980 Annual Meeting—Reviewed by Board, 1987)

Reimbursement for Outpatient Services

Third-party payors should be encouraged to provide coverage for outpatient diagnostic tests and surgery.
(1980 Annual Meeting—Reviewed by Board, 1986)

Reimbursement for Treating Medicaid Patients

The Illinois State Medical Society approves in principle the concept of amending appropriate state and federal laws to provide physicians with the option of taking state and federal income tax credits or deductions in lieu of direct reimbursement for the treatment of Public Aid recipients.
(1981 Annual Meeting—Reviewed by Board, 1987)

Reimbursement, Physician

It is desirable to afford maximum flexibility and latitude in creating an economic environment acceptable to the individual physician's right to choose which method of economic reimbursement for care that best suits the needs of that physician and his/her patients. Where appropriate, ISMS supports the right of physicians to seek payment from patients for the difference between the physician's charges and the amount of payment an insurance carrier pays. To the extent practicable, ISMS should strive to assist physicians in understanding alternative reimbursement systems, including but not limited to Usual and Customary or Reasonable (UCR).
(Amended, 1985 Annual Meeting)

Risk Management

ISMS supports the policy that: (1) Hospital medical staffs recognize the relevance of hospital risk management programs to help protect the hospital, the medical staff and hospital personnel from unnecessary claims and lawsuits; (2) Risk management activity should not adversely affect the ability of a physician from exercising his legal and professional responsibilities to practice medicine and ensure quality care; and (3) The hospital medical staff should be the primary resource which works with the hospital to establish those elements of risk management which directly affect patient medical care.
(1986 Annual Meeting)

Seatbelt Use

The Illinois State Medical Society supports the voluntary use of seatbelts and other passenger restraint devices as effective methods of reducing injury and death in motor vehicle accidents. It supports state legislation requiring that all school buses be equipped with passenger safety restraints and other structural modifications to assure maximum impact safety.
(Amended, 1983 Annual Meeting)

Smoking

The Illinois State Medical Society, as a matter of policy, publicly adopts a vigorous stand against cigarette smoking because it is a major health hazard. The Society will work with other agencies inside and outside medicine to eliminate this contributory cause of death, disability and rising health care cost. ISMS will support appropriate legislative initiatives to communicate the risks of tobacco to all, particularly young people.

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and encourages medical staff action to make hospitals tobacco smoke-free, except for certain areas designated for smoking.

Physicians should refrain from smoking during professional patient visits. Exemplary abstinence during social contacts by physicians and their employees with the public in general is highly desirable. Literature and signs concerning the health hazards of smoking should be displayed in medical offices and other public places over which health

care professionals have control.
(Amended, 1985 Annual Meeting)

Surgery, Reconstructive

Reconstructive surgery is surgery which is intended to correct deformities caused by disease or accident.
(Amended, 1985 Annual Meeting)

Surgery, Second Opinion for

Recognizing that the advisability of surgery or other special therapy can be a matter of opinion, the Illinois State Medical Society (1) reaffirms the right of the patient to seek a second opinion freely from any physician of his/her choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third-party payor for not obtaining a second opinion; and (3) supports the concept that, when a second opinion is required by a third-party payor, that second opinion should be at no cost to the patient.
(1979 Annual Meeting—Reviewed by Board, 1986)

Third Party Intrusion Into Medical Judgment

Medical judgment and decision-making power of the treating physician must not be abrogated by third party payors. ISMS is opposed to any third party having the power of decision as to medical necessity of services and supplies, including hospitalization over and above the judgment of the treating physician.
(1978 Annual Meeting)

Third Party Payor Relationships

ISMS should provide appropriate guidance, education, and communication between the membership and third party payors.

When third party payors fail to provide releases from patients when further information is requested it should not delay reimbursement for physicians services.
(Amended 1988 Annual Meeting)

Tobacco Farm Subsidies

The Illinois State Medical Society opposes the subsidization or price supports of tobacco farming.
(1982 Annual Meeting—Reviewed by Board, 1987)

Violence

The Illinois State Medical Society opposes the ready accessibility to hand guns without evidence of responsibility on the part of the possessor and urges strict enforcement of present federal, state and city laws and that the courts, as well as the legislature, impose maximum penalties on all offenders.

The Illinois State Medical Society will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including the offering of rewards and other incentives in the solution of such cases.
(1978 Annual Meeting—Reviewed by Board, 1986)

Withdrawing or Withholding Life-Prolonging Treatment

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his/her family or legal representative (if the patient is incompetent to act in his/her own behalf) should prevail. In the absence of the patient's choice or an authorized proxy, the physician must act in the best interest of the patient.

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient, whose death is imminent, to die.

In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act on his/her own behalf, the physician should determine what the possibility is for extending life under humane and comfortable conditions and what are the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody of the patient.

Even if death is not imminent, but a patient's coma is beyond doubt irreversible and there are adequate safe-guards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment.

Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweight its burdens. At all times the dignity of the patient should be maintained.
(1987 Annual Meeting)

Workers Compensation

The Illinois State Medical Society opposes the need for repeat radiology examinations of the same bodily part or parts performed in the course of evaluating an individual in a worker's compensation case, unless a significant change in the patient's condition has taken place or is suspected. The referring physician should furnish all pertinent X-rays and records to the examining physician within an appropriate period.
(Amended 1988 Annual Meeting)

ADMINISTRATIVE POLICIES

AMA-ERF

The AMA-ERF contributions for Illinois graduates shall be distributed to the Illinois medical school from which the member graduated.

The contribution for the balance of the membership shall be distributed to Illinois medical schools in the same proportion as above.

Any member may over-ride this procedure and designate a school of choice by advising ISMS in writing.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1987)

Autonomy of County Medical Societies

In all areas, the county medical society shall be autonomous. Actions of any county medical society should conform with the Constitution and Bylaws of the Illinois State Medical Society.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1987)

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Individual tenure on any committee should be limited to a maximum of five years of continuous membership.

Physicians appointed to Illinois State Medical Society committees must be members in good standing of this Society.
(1978 Interim Meeting—Reviewed by Board, 1986)

Councils and Committees

It is the policy of the Board of Trustees to encourage evening or weekend meetings of councils and committees at convenient locations to improve membership involvement in council and committee activities.
(1981 Annual Meeting—Reviewed by Board, 1986)

Disciplinary Action

The Illinois State Medical Society will immediately communicate any disciplinary action by the Department of Professional Regulation to the appropriate county society.
(1980 Interim Meeting—Reviewed by Board, 1986)

Dues Approval Procedure

All financial matters involving changes in dues, dues structure, allocation of dues, or levying of assessments in any such manner shall be distributed to all delegates and alternate delegates and to all presidents and secretaries of county medical societies at least thirty days prior to the convening of the House of Delegates.
(1980 Annual Meeting—Reviewed by Board, 1987)

Dues Stabilization, Membership

The Illinois State Medical Society should 1) carefully consider the delicate balance of dues and membership and 2) maintain reasonable dues within the context of budgetary reviews and long-range planning in order to preserve medicine's strength by member involvement and participation.
(1985 Annual Meeting)

Election of AMA Delegates

Delegates to the American Medical Association should be elected from those having served first as alternate delegates.

The Resident Physicians Section and the Medical Student Section shall recommend to the chairman and the secretary of the AMA Delegation the names of residents and students to be appointed to fill any alternate delegate vacancy on a temporary basis.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1987)

Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for elections as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.
(1977 Annual Meeting—Reviewed by Board, 1987)

Honoraria For Officers

The Finance Committee is instructed to evaluate annually the honoraria paid to ISMS officers and to recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.
(1978 Annual Meeting—Reviewed by Board, 1987)

Illinois Medical Journal

The Publications Committee, with approval of the Board of Trustees, has authority to carry out publication policy. The committee is responsible for screening proposed advertising copy and advertisers, as well as for direction of the editorial content.

ISMS asserts the right to first refusal of original papers presented at programs for which ISMS is primary fiscal sponsor.
(1981 Annual Meeting—Reviewed by Board, 1987)

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with the Society's basic philosophy.
(Prior to 1965—Reviewed by Board, 1986)

Informing the Membership

The membership of the Illinois State Medical Society shall have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal;*
2. Brief notice in Action Report, whenever possible, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

(Amended, 1982 Annual Meeting—Reviewed by Board, 1987)

ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.
(Prior to 1965—Reviewed by Board, 1987)

ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils or major committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except when emergency action is necessary because of unexpected vacancies.

Nomination for appointments to subcommittees, ad hoc committees, other minor committees of AMA or as AMA representatives to certain outside agencies may be made directly by the Chairman of the ISMS Board of Trustees, after consultation with the Chairman of the ISMS Delegation, without specific approval of the full Board of Trustees or AMA Delegation. Such action shall be reported to the Board of Trustees and the AMA Delegation.

Upon receiving notice that an Illinois physician has been nominated for AMA position by an organization other than ISMS, the Chairman of the ISMS Board of Trustees, pursuant to the recommendation of the Chairman of the AMA Delegation, shall inform AMA only whether or not the nominee is a member in good standing of ISMS.
(Amended, 1981 Interim Meeting—Reviewed by Board, 1987)

Legal Counsel

The legal counsel of the Illinois State Medical Society shall serve the Society at the direction of the Board of Trustees. Counsel shall respond to official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Board of Trustees.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1987)

Legislation

All matters presented to the House of Delegates or Board of Trustees pertaining to state or federal legislation shall be reviewed by the Governmental Affairs Council, which shall evaluate its potential impact on the Society's current legislative efforts. The council shall submit its report to the Board of Trustees, which shall advise and recommend action to the House through the Chairman of the Board.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Governmental Affairs Council of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs and with Board approval shall work in close cooperation with any other society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any council or committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House committees in support of, or in opposition to, the legislation recommended by the council or committee and with Board approval.
(Amended, 1981 Interim Meeting—Reviewed by Board, 1987)

Mailing List

The use of the mailing list of ISMS members must be approved by the Board of Trustees.
(Amended, 1980 Annual Meeting—Reviewed by Board, 1987)

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the state society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Only physicians appointed to the boards and committees of other organizations who are endorsed by their local county medical society shall be considered "representative" of the medical community.
(1978 Interim Meeting—Reviewed by Board, 1987)

National Library of Medicine

The Illinois State Medical Society supports the programs of the National Library of Medicine. Fees for subscribers should be based on the current accounting system rather than on total costs.
(1982 Interim Meeting)

Participation in Service Organizations

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1986)

Physician Recruitment Service

The Illinois State Medical Society shall coordinate activities connected with recruiting doctors to practice in Illinois. It shall maintain a Physician Recruitment Service to disseminate information about physician-short communities to doctors in training in Illinois and to those who have indicated to the service that they wish to relocate in Illinois. It shall take an active role with other organizations in Illinois conducting recruitment activities.
(Amended, 1985 Annual Meeting)

Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.
(1976 Interim Meeting—Reviewed by Board, 1987)

Press

In order to provide the public with prompt and accurate information on all health-related matters, all county medical societies are encouraged to cooperate with the local news media.

County medical societies are responsible for providing their local media with information concerning official county society statements or actions, and should serve as a source of information on health issues of local concern.

The state society is solely responsible for disseminating information on its official actions, statements or views of the Illinois State Medical Society on issues with statewide or national implications.
(1980 Interim Meeting—Reviewed by Board, 1987)

Public Statements

Only officially designated persons may publicly speak for the society. The chairman of the Board of Trustees, at the request of the President, shall designate ISMS spokesmen.

Spokesmen should bear in mind that, as representatives of the society, they should refrain from expressing their personal views. Their public statements should be—to the best of their ability—in consonance with the society's policies and positions.
(1978 Annual Meeting—Reviewed by Board, 1987)

Public Statements, Endorsements

No officer, member of the Board of Trustees, council or committee chairman or staff member is permitted (during his term of office or employment) to allow his name and ISMS title to be used in lists endorsing candidates for public office. No one shall use the official Illinois State Medical Society stationery for personal statements of any nature, including the endorsement of any candidate for public office.
(1980 Annual Meeting—Reviewed by Board, 1987)

Reference Service

County medical societies should establish procedures for referral of patients seeking physician services. It is appropriate to announce the availability of such an activity via the news media as a public service. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.
(Amended, 1980 Interim Meeting—Reviewed by Board, 1987)

Resident Physician Membership

Each regular member of ISMS is encouraged to recruit at least one resident physician member every year, with the regular member providing assistance to the resident in completing the application process for membership.

The Governing Council of the ISMS Resident Physicians Section will serve in an advisory role for component societies planning resident participation at the local level.
(Amended, 1983 Annual Meeting)

Resolutions

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS.
(1976 Interim Meeting—Reviewed by Board, 1987)

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable.

Recognized medical specialty societies as approved by the Board of Trustees shall be invited to submit recommendations for appointment to ISMS councils. Persons so recommended shall be members of both ISMS and the specialty society making the recommendation.

(1979 Annual Meeting—Reviewed by Board, 1987)

Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.
(1974 Annual Meeting—Reviewed by Board, 1987)

Policy Manual Appendix

State Regulation on Physician Advertising

The Illinois legislature passed a new Medical Practice Act which governs advertising by physicians and which came into effect as of May 22, 1987. The Illinois Department of Professional Regulation, which is responsible for implementation of the law, will provide regulations for implementation. The pertinent sections of the Medical Practice Act are as follows:

Section 26.

Any person licensed under the Act may advertise the availability of professional services in the public media or on the premises where such professional services are rendered. Such advertising shall be limited to the following information:

(a) Publication of the person's name, title, office hours, address and telephone number;

(b) Information pertaining to the person's areas of specialization, including appropriate board certification or limitation of professional practice;

(c) Information on usual and customary fees for routine professional services offered, which information shall include, notification that fees may be adjusted due to complications or unforeseen circumstances;

(d) Announcement of the opening of, change of, absence from, or return to business;

(e) Announcement of additions to or deletions from professional licensed staff;

(f) The issuance of business or appointment cards.

It is unlawful for any person licensed under this Act to use testimonials or claims of superior quality of care to entice the public. It shall be unlawful to advertise fee comparisons of available services with those of other persons licensed under this Act.

This Act does not authorize the advertising of professional services which the offeror of such services is not licensed to render. Nor shall the advertiser use statements which contain false, fraudulent, deceptive or misleading material or guarantees of success, statements which play upon the vanity or fears of the public, or statements which promote or produce unfair competition.

Section 27.

It is unlawful and punishable under Section 59 for any person licensed under this Act to knowingly advertise that the licensee will accept as payment for services rendered by assignment from any third party payer the amount the third party payor covers as payment in full, if the effect is to give the impression of eliminating the need of payment by the patient of any required deductible or copayment applicable in the patient's health benefit plan.

As used in this Section, "advertise" means solicitation by the licensee or through another by means of handbills, posters, circulars, motion pictures, radio, newspapers, television or in any other manner.

Trustee District Committees

First District

David B. Littman, Highland Park, *Trustee*
Counties of Kane, Lake, McHenry

Ethical Relations Committee	Term Expires
Gerald J. Liesen, St. Charles, *Chairman*	1991
A. M. Rossetti, McHenry	1989
Donald M. Coder, Lake Forest	1990

Peer Review Committee	
James C. Pritchard, Geneva, *Chairman*	1990
Edward F. Wilt, Crystal Lake	1990
Albino T. Bismonte, Gurnee	1990

Second District

Ross N. Hutchison, Gibson City, *Trustee*
Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford

Ethical Relations Committee	Term Expires
William E. Erkonen, Streator, *Chairman*	1989
Julius M. Kowalski, Princeton	1989
Lawrence D. Lee, Manhattan	1991
Merle L. Otto, Frankfort	1991

Peer Review Committee	
D.G. Parkhurst, Kankakee, *Chairman*	1989
James B. Aplington, LaSalle	1991
Robert Bettasso, Ottawa	1991
Silvio Davito, Spring Valley	1991
Bernard J. Doyle, Peru	1991
William E. Ehling, Streator	1989
Alex J. Spadoni, Joliet	1991
Theodore W. Wagenknecht, Streator	1991
John H. Kendall, Joliet	1990

Third District

James H. Andersen, Oak Brook, *Trustee*
H. Constance Bonbrest, Chicago, *Trustee*
Alfred J. Clementi, Arlington Heights, *Trustee*
Audley F. Connor, Jr., Chicago, *Trustee*
Ulrich F. Danckers, River Forest, *Trustee*
Harold L. Jensen, Harvey, *Trustee*
M. Anita Johnson, Hickory Hills, *Trustee*
William J. Marshall, Olympia Fields, *Trustee*
Adriano S. Olivar, Chicago Heights, *Trustee*
Robert M. Vanecko, Chicago, *Trustee*

Fourth District

Lorris M. Bowers, Peoria, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren

Ethical Relations Committee	Term Expires
Jerry Ramunis, Galesburg, *Chairman*	1991
Kenneth E. Ambrose, Monmouth	1991
Even Kvelland, Geneseo	1990

Peer Review Committee	
James C. Parsons, Geneseo, *Chairman*	1991
Donald H. Dexter, Macomb	1989
William Dougherty, Moline	1990
Richard M. Flacco, Galesburg	1991
Lorin D. Whittaker, Jr., Peoria	1990
Thomas G. Cassidy, Peoria	1990

Fifth District

Michael C. Snyder, Springfield, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon

Ethical Relations Committee	Term Expires
Richard H. Suhs, Springfield, *Chairman*	1989
Jack Means, Mason City	1990
A.L. Van Ness, Bloomington	1991

Peer Review Committee	
Albert Cunningham, Normal, *Chairman*	1989
Robert B. Perry, Lincoln	1991
Donald H. Yurdin, Springfield	1991

Sixth District

George T. Wilkins, Jr., Edwardsville, *Trustee*

Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott

Ethical Relations Committee	Term Expires
Edward K. DuVivier, Alton, *Chairman*	1989
Bernard M. Baalman, Hardin	1990
C.B. Lara, Pittsfield	1990
Robert M. Roy, Jr., Jacksonville	1990

Peer Review Committee	
Walter Stevenson, III, Quincy, *Chairman*	1989
Robert G. England, Carlinville	1990
Robert F. Hamilton, Godfrey	1990
Edward F. Ragsdale, Alton	1989
James W. Sutherland, Quincy	1989

Seventh District

Alfred J. Kiessel, Decatur, *Trustee*

Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby

Ethical Relations Committee	Term Expires
Delbert H. Hahn, Jr., Decatur, *Chairman*	1991
Theodore C. Little, Shelbyville	1991
E. Doyle Slifer, Taylorville	1989

Peer Review Committee	
H. Gale Zacheis, Decatur, *Chairman*	1989
Ruben Boyajian, Effingham	1989
Clarence G. Glenn, Decatur	1991
D.H. Rames, Vandalia	1991

Eighth District

Arthur R. Traugott, Urbana, *Trustee*

Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion

Ethical Relations Committee	Term Expires
Mack W. Hollowell, Charleston, *Chairman*	1989
Victor F. Feldman, Champaign	1991
Stanley R. Huffman, Charleston	1989
Gerald Mastio, Olney	1990

Peer Review Committee	
George T. Mitchell, Marshall, *Chairman*	1990
David W. Morse, Urbana	1991
Robert Swengel, Neoga	1990
Edward S. Warren, Danville	1991

Ninth District

Phillip D. Boren, Carmi, *Trustee*

Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson

Ethical Relations Committee	Term Expires
Richard L. Morgan, Marion, *Chairman*	1991
Eli Borkon, Carbondale	1989
Paul P. Lorenz, Carbondale	1989

Peer Review Committee	
Larry R. Jones, Harrisburg, *Chairman*	1990
Michael A. Blood, Cisne	1991
M. H. Desai, Mt. Vernon	1991
William F. Hays, Herrin	1990
Roger N. Klam, Carbondale	1990

Tenth District

Ronald G. Welch, Belleville, *Trustee*

Counties of Monroe, Perry, Randolph, St. Clair, Washington

Ethical Relations Committee	Term Expires
H. P. Dexheimer, Belleville, *Chairman*	1991
Charles R. Frazer, E. St. Louis	1991
Edilberto F. Maglasang, Columbia	1991
Wm. A. Simmons, Belleville	1991

Peer Review Committee	
Theodore L. Bryan, Belleville, *Chairman*	1990
Henry M. Hurd, Belleville	1991
Alan L. Liefer, Red Bud	1990
R. E. Schettler, Red Bud	1989

Eleventh District

Raymond A. Dieter, Jr., Glen Ellyn, *Trustee*

County of DuPage

Twelfth District

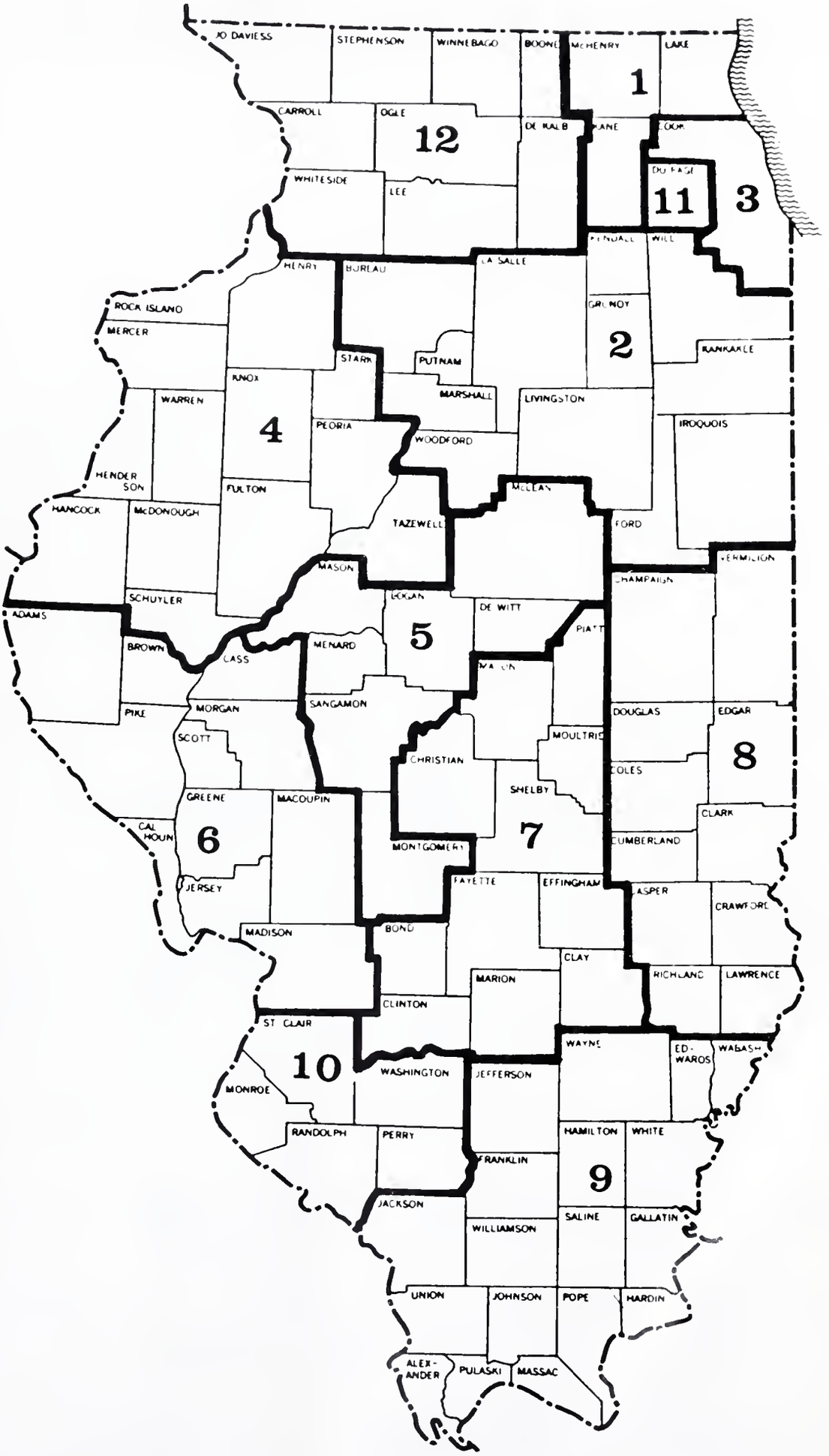
Raymond E. Hoffmann, Rockford, *Trustee*

Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago

Ethical Relations Committee	Term Expires
John H. Steinkamp, Belvidere, *Chairman*	1990
David K. Deets, Dixon	1989
Edward D. Maglietta, Freeport	1989
Daniel L. Swift, Rockford	1990

Peer Review Committee	
John H. Steinkamp, Belvidere, *Chairman*	1990
David K. Deets, Dixon	1989
Edward D. Maglietta, Freeport	1989
Daniel L. Swift, Rockford	1990

ISMS TRUSTEE DISTRICTS



1988 Officers of County Medical Societies

County	*Members*	*President*	*Secretary*
Adams	Members: 109-Dist. 6 Maxine Boyer, Ex. Sec., 2039 Sunnybrook, P.O. Box 767, Quincy 62306	Dan H. Evans 1101 Maine St., Quincy 62301	Richard L. Newman P.O. Box 450, Quincy 62306
Alexander-Pulaski	Members: 4-Dist. 9	Crisostomo F. Lozada 529 Cross St., Cairo 62914	Gemo Y. Wong 529 Cross St. Cairo 62914
Bond	Members: 10-Dist. 7	M. Kenneth Kaufmann 308 W. College Ave., Greenville 62246	James R. Goggin 207 N. Second St., Greenville 62246
Boone	Members: 23-Dist. 12	Alan W. Sherman 1221 E. State St., Rockford 61108	Jaime F. Sanz 303 Andrews Dr., Belvidere 61008
Bureau	Members: 34-Dist. 2	Edward Doran Perry Memorial Hospital, 530 Park Ave. East, Princeton 61356	Frank Matheu Perry Memorial Hospital, 530 Park Ave. East, Princeton 61356
Carroll	Members: 6-Dist. 12	Benjamin M. Sy 333 Chicago Ave., Savanna 61074	Lemuel B. Hussey 333 Chicago Ave., Savanna 61074
Champaign	Members: 337-Dist. 8 Larry Booth, Ex. Sec., 11½ E. University Ave., Suite A Champaign 61820	Norris Hansell 101 W. University Ave., Champaign 61820	David W. Morse Carle Clinic Association 602 W. University, Urbana 61801
Christian	Members: 20-Dist. 7	Jui-Long Yang Christian County Medical Clinic, 600 N. Main St., Taylorville 62568	Ignacio Del Valle 311 S. Main St., Taylorville 62568
Clark	Members: 5-Dist. 8	George T. Mitchell Cork Medical Center, Marshall 62441	Steven Macke Cork Medical Center, Marshall 62441
Clay	Members: 6-Dist. 7		Nashaat H. Naam 318 S. Walnut, Clay City 62824
Clinton	Members: 20-Dist. 7	Venerio M. Santos Jamestown Road, P.O. Box 99, Breese 62230	James A. Kirby P.O. Box 384, Breese 62230
Coles-Cumberland	Members: 59-Dist. 8	Kiran V. Joag Link Clinic, 1710 Wabash Ave., Mattoon 61938	Mark R. Dettro Link Clinic, 1710 Wabash, Mattoon 61938
Cook	Members: 10,380-Dist. 3 Fred Schwartz, Exec. Dir., 515 N. Dearborn St., Chicago 60610	James H. Andersen 141 Breakenridge Farm, Oak Brook 60521	Arvind K. Goyal 550 E. Alexandra Court, Itasca 60143

County	*Members*	*President*	*Secretary*
Crawford	Members: 15-Dist. 8	Gregory P. Kastner CMH Medical Center, 1000 N. Allen, Suite B, Robinson 62454	W.B. Schmidt 408 S. Cross St., Robinson 62454
DeKalb	Members: 68-Dist. 12	Periakaruppan Ramanathan 2535 Bethany Rd., Suite 110, Sycamore 60178	Richard A. Lane Dekalb Clinic 217 Franklin St., DeKalb 60115
DeWitt	Members: 10-Dist. 5	John W. Veirs 219 E. Main St., P.O. Box 348 Clinton 61727	C. N. Radhakrishna 210 E. Main St., Clinton 61727
Douglas	Members: 11-Dist. 8	Grant A. Jones 318 S. Ash Arthur 61911	Robert N. Arrol 126 S. Locust Arcola 61910
DuPage	Members: 868-Dist. 11 Kirk McMurray, Ex. Admin., 800 Roosevelt Road, Building B-Suite 300, Glen Ellyn 60137	Vedantham Srinivasan 10 W. Martin, Naperville 60540	James P. Campbell, Jr. 322 N. Blanchard St., Wheaton 60187
Edgar	Members: 13-Dist. 8	Leland A. Phipps Medical Center Clinic, 502 Shaw, Paris 61944	Reid E. Sutton 110 W. Washington, Paris 61944
Effingham	Members: 24-Dist. 7	Louis Beis P.O. Box 608 Effingham, 62401	
Fayette	Members: 11-Dist. 7	Donald H. Rames 1029 N. Eighth St., Vandalia 62471	Hans Rollinger 1003 N. Eighth St., Vandalia 62471
Ford	Members: 12-Dist. 2	Ross N. Hutchison 126 E. 9th St., P.O. Box 388, Gibson City 60936	David J. Hagan 214 N. Sangamon, Gibson City 60936
Franklin	Members: 28-Dist. 9	Basil A. Moskoff 7 W. Maryland St., Zeigler 62999	Bob G. Thompson The Professional Building 309 W. St. Louis St., W. Frankfort 62896
Fulton	Members: 37-Dist. 4	Linda K. Forestier Coleman Clinic 175 S. Main St. Canton 61520	Peter P. Chang Coleman Clinic 175 S. Main St. Canton 61520
Gallatin	Members: 1-Dist. 9	John E. Doyle Rte 1, Ridgway 62979	John E. Doyle Rte 1, Ridgway 62979
Greene	Members: 9-Dist. 6	Gary L. Turpin Fillanger Memorial Clinic, 712 S. College Ave., Greenfield 62044	James C. Reid Fillanger Memorial Clinic 712 S. College, Greenfield 62044
Hancock	Members: 9-Dist. 4	Vasant F. Pawar Memorial Hospital, End South Adams St., Carthage 62321	James E. Coeur 630 Locust St., Carthage 62321
Henderson	Members: 1-Dist. 4	Silvino C. Lindo, Jr. P.O. Box 248, Biggsville 61418	Silvino C. Lindo, Jr. P.O. Box 248, Biggsville 61418
Henry-Stark	Members: 33-Dist. 4	Even Kvelland 648 N. Chicago St., Geneseo 61254	Randall L. Mullin 648 N. Chicago St. Geneseo 61254

County	*Members*	*President*	*Secretary*
Iroquois	Members: 24-Dist. 2	John R. Schlereth 101 W. Cherry St., Watseka 60970	Phillip F. Zumwalt 125 S. Fourth St., Watseka 60970
Jackson	Members: 91-Dist. 9	Dale W. Blaise 215 N. 14th St., Murphysboro 62966	Frank L. Bleyer 1001 N. Oakland, Carbondale 62901
Jasper	Members: 1-Dist. 8	Monico Low P.O. Box 377, 609 S. Van Buren St., Newton 62448	Monico Low P.O. Box 377, 609 S. Van Buren St., Newton 62448
Jefferson-Hamilton	Members 47-Dist. 9	Thomas J. Weinberg P.O. Box 1604, Mt. Vernon 62864	Daniel R. Hoffman 23 Hawthorne Hills, Mt. Vernon 62864
Jersey-Calhoun	Members: 17-Dist. 6	Roger A. Schroeder P.O. Box 7 Jerseyville 62052	Bernard M. Baalman Medical Center, Hardin 62047
Jo Daviess	Members: 10-Dist. 12	Wilbur E. Johnson 219 Summit St., Galena 61036	David R. Smith 219 Summit St., Galena 61036
Kane	Members: 357-Dist. 1 H. Michael Wild, Ex. Dir., 355 First St., Batavia 60510	Robert K. Dean 123 South St., Suite 240 Geneva 60134	Lawrence Kosinski 860 Summit St., Elgin 60120
Kankakee	Members: 110-Dist. 2 Joan Moody, Exec. Sec., St. Mary's Hosp., 500 W. Court St., Kankakee 60901	Milton J. Smit 400 N. Wall St., Suite 101, Kankakee 60901	Charles F. Lind St. Mary's Hospital 500 W. Court St., Kankakee 60901
Kendall	Members: 5-Dist. 2	John P. Cullinan 126 S. Main St., Oswego 60543	Joseph L. Daw 126 S. Main St., Oswego 60543
Knox	Members: 82-Dist. 4 Jane Gau, Exec. Sec., Galesburg Cottage Hospital 695 N. Kellogg, Galesburg 61401	Madan L. Gupta 3315 N. Seminary St., Galesburg 61401	Donald R. Fisk 765 N. Kellogg St., Galesburg 61401
Lake	Members: 584-Dist. 1 Jane R. Stein, Exec. Dir., 1117 S. Milwaukee Ave., Forum Two-Suite 11, Libertyville 60048	Richard C. Gayes 450 W. Highway 22, Suite 19, Barrington 60010	Mark Nolan Hill 625 Roger Williams Ave., Highland Park 60035
LaSalle	Members: 114-Dist. 2	William J. Farley 710 Peoria St., Peru 61354	Caner Celeboglu 104 6th St., P.O. Box 828, Streator 61364
Lawrence	Members: 13-Dist. 8 Donna Carter Executive Secretary, Lawrence County Memorial Hosp., West State St., Lawrenceville 62439	Gary D. Carr R.R. #4, Box 1, Lawrenceville 62439	Frank E. Martin 542 N. Main St., Bridgeport 62417
Lee	Members: 25-Dist. 12	David K. Deets 100 Ravine Ave., Dixon 61021	Dominador T. Martin, Jr. 101-1/2 W. Mason, Polo 61064
Livingston	Members: 31-Dist. 2	Rajendra Shrivastav St. James Professional Bldg., Suite 107, Pontiac 61764	Kenneth D. Velez 109 W. Howard St., Pontiac 61764

County	*Members*	*President*	*Secretary*
Logan	Members: 24-Dist. 5	Jose D. Pineda 316 Eighth St., Lincoln 62656	James B. Borgerson 119 S. Vine St., Mt. Pulaski 62548
Macon	Members: 172-Dist. 7 Mary J. Bretz, Ex. Sec., 1800 E. Lake Shore Dr., Decatur 62521	Robert G. Canham Medical Office Bldg., 1770 E. Lake Shore Dr., Suite 205, Decatur 62521	Robert R. Kraus 462 W. William, Decatur 62522
Macoupin	Members: 20-Dist. 6	Emerito F. Ureta 428 Caldwell, Suite 20, Staunton 62088	Robert G. England 1115 Morgan, Carlinville 62626
Madison	Members: 244-Dist. 6	Edward F. Ragsdale Alton Memorial Hospital, Memorial Drive, Alton 62002	Norman E. Taylor 95 S. 9th St., E. Alton 62024
Marion	Members: 55-Dist. 7	Prashant B. Shah 1050 E. McCord St., Centralia 62801	Mary K. Markle 1201 E. Broadway, Centralia 62801
Marshall-Putnam	Members: 3-Dist. 2	Don M. Gallagher P.O. Box 583 Granville 61326	Jan R. Hill Lacon Clinic, 202 S. Main St., Lacon 61540
Mason	Members: 4-Dist. 5	Henry W. Maxfield 715 E. Chestnut St., Mason City 62664	Henry W. Maxfield 715 E. Chestnut St., Mason City 62664
Massac	Members: 5-Dist. 9	Bharat K. Patel Memorial Heights P.O. Box 191, Metropolis 62960	Randy E. Oliver 600 Ferry St., Metropolis 62960
McDonough	Members: 37-Dist. 4	Richard C. Watson 525 E. Grant St., Macomb 61455	Robert E. Stallworth 525 E. Grant St., Macomb 61455
McHenry	Members: 110-Dist. 1	Edward F. Wilt, Jr. 330 W. Terra Cotta, Crystal Lake 60014	Richard E. Lind 451 Conventry Green Bldg., Suite 101, Crystal Lake 60014
McLean	Members: 175-Dist. 5 Madge Williams, Exec. Adm., 1236 E. Empire St., Bloomington 61701	Ashvin K. Patel Brokaw Fndtn. Prof. Care, 1300 Franklin Ave., Suite 270, Normal 61761	Lawrence A. Raines 2304 E. Oakland, Bloomington 61701
Mercer	Members: 4-Dist. 4	Suresh L. Abad 112 N. College Ave., Aledo 61231	Dennis D. Palmer 409 N.W. 4th St., Aledo 61231
Monroe	Members: 12-Dist. 10	Edilberto F. Maglasang 109 W. Legion, Columbia 62236	William H. Winkler 650 N. Market, P.O. Box 208 Waterloo 62298
Montgomery	Members: 25-Dist. 5		Roger Wujek 1225 E. Union Ave., Litchfield 62056
Morgan-Scott	Members: 44-Dist. 6	Lemuel Villanueva 1602 W. Lafayette, Jacksonville 62650	Chandupatla Prabhakar 1606 W. Lafayette, Jacksonville 62650
Moultrie	Members: 3-Dist. 7	Phillip H. Best 14 N. Washington, Sullivan 61951	Phillip H. Best 14 N. Washington, Sullivan 61951

County	*Members*	*President*	*Secretary*
Ogle	Members: 14-Dist. 12	Juanito E. Delfinado 915 Caron Rd., Rochelle 61068	Russell W. Zack 125 Joanne Lane, Rochelle 61068
Peoria	Members: 514-Dist. 4 M. John Hanni, Jr., Ex. V.P., 434 1st Nat'l Bank Bldg., Peoria 61602	James R. DeBord Hillcrest Medical Plaza, 420 N.E. Glen Oak, #301, Peoria 61603	Ben J. Dolin 120 N.E. Glen Oak, Peoria 61603
Perry	Members: 12-Dist. 10	Raghuveer M. Kudva, 900 N. Washington P.O. Box 425, DuQuoin 62832	John G. Fozard 206 N. Main, Pickneyville 62274
Piatt	Members: 6-Dist. 7	William E. Mundt 499 N. Buchanan, Monticello 61856	William E. Mundt 499 N. Buchanan, Monticello 61856
Pike	Members: 10-Dist. 6	Ansar U. Ansari 623 W. Washington, Pittsfield 62363	Ronald L. Johnson 112 W. Jefferson Pittsfield 62363
Randolph	Members: 23-Dist. 10	Robert E. Schettler 824 Locust St., Red Bud 62278	David A. Walls 415 W. S. 4th Street, Suite 4, Red Bud 62278
Richland	Members: 27-Dist. 8	Arcot D. Suresh Weber Medical Clinic, 1200 N. East St., Olney 62450	Mary L. Budzak Richland Memorial Hospital, 800 E. Locust, Outpatient Clinic, Olney 62450
Rock Island	Members: 224-Dist. 4 James A. Koch, Ex. V.P. 608 Kahl Bldg., 326 W. Third St., Davenport, Iowa 52801	Philip T. Siegert 1508 7th St., Suite 602, Moline 61265	J. Fred Green 1231 13th St., East Moline 61244
St. Clair	Members: 280-Dist. 10 Adrienne Noubarian, Ex. Dir., 6400 W. Main, Suite 3L, Belleville 62223	Stephen R. Kappel 8601 W. Main St., Belleville 62223	Anthony Galloway 10 W. Harrison St., Belleville 62220
Saline-Pope-Hardin	Members: 23-Dist. 9	Larry R. Jones Professional Arts. Bldg., 607 S. Commercial, Harrisburg 62946	Steven D. Knight Doctor's Clinic Ltd. 1201 Pine St., Eldorado 62930
Sangamon	Members: 592-Dist. 5 Sharon L. Bell, Exec. Dir., 611 N. 6th St. Lower Level Springfield 62702	Marion S. Panepinto Springfield Clinic, 1025 South 7th St., Springfield 62703	Victor H. Lary St. Johns Hosp., 800 E. Carpenter, Springfield 62769
Schuyler	Members: 7-Dist. 4	Robert E. Cox 206 S. Monroe, Rushville 62681	Henry C. Zingher 110 N. Congress, Rushville 62681
Shelby	Members: 11-Dist. 7	Theodore C. Little 207 S. Pine, Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
Stephenson	Members: 69-Dist. 12	Bhadresh A. Patel 750 S. Kiwanis Dr., Freeport 61032	Alan E. Esker Freeport Clinic 1036 W. Stephenson St., Freeport 61032
Tazewell	Members: 68-Dist. 4 Colleen Ingersoll, Exec. Sec., P.O. Box 778, Pekin 61554	Ronald Hake Morton Medical Center, 1600 S. Fourth St., Morton 61550	M.A. Sheikh 2900 W. Kingston Ct., Peoria 61604

County	*Members*	*President*	*Secretary*
Union	Members: 8-Dist. 9		Carroll O. Loomis Union County Hosp., P.O. Box 260, 517 Main St., Anna 62916
Vermilion	Members: 103-Dist. 8	Marvin L. Hoovis 806 N. Logan, Danville 61832	Michael K. Lomax 917 N. Walnut, Danville 61832
Wabash	Members: 7-Dist. 9	Larry P. Jennings 210 W. 4th St., Mt. Carmel 62863	Larry P. Jennings 210 W. 4th St., Mt. Carmel 62863
Warren	Members: 15-Dist. 4	James W. Marshall 319 N. Main St., Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
Washington	Members: 4-Dist. 10	Thomas J. Coy 113 W. St. Louis St. P.O. Box 307, Nashville 62263	Ralph H. Kelley 113 W. St. Louis St. P.O. Box 307, Nashville 62263
Wayne	Members: 14-Dist. 9	Michael A. Blood Cisne Clinic, P.O. Box 249, Cisne 62823	Merle H. Muller Cisne Clinic, P.O. Box 249, Cisne 62823
White	Members: 8-Dist. 9	Zahid Saqib East Main St., Norris City 62869	Shafi U. Syed 786 S. Hwy. 1 Crossville 62827
Whiteside	Members: 55-Dist. 12	Joseph H. Gaziano 101 E. Miller Rd., Sterling 61081	Sterling H. Baumwell 202 W. Miller Rd., Sterling 61081
Will-Grundy	Members: 267-Dist. 2 Ronald Batozech, Ex. Sec., 3033 W. Jefferson, Suite 220, P.O. Box 2368, Joliet 60435	Mark R. Sinibaldi 3033 W. Jefferson St. P.O. Box 2368 Joliet 60435	Augustine Roland 1301 Copperfield Ave., Joliet 60432
Williamson	Members: 49-Dist. 9	William F. Hays 315 S. Fourteenth, Herrin 62948	Herman O. Lyle, Jr. P.O. Drawer 820, Marion 62959
Winnebago	Members: 499-Dist. 12 Robert Carlson, Exec., Adm., 630 E. Jefferson, Rockford 61107	James W. Girardy 5668 East State St., Rockford 61108	Dennis G. Norem 5970 Churchview Dr., Rockford 61107
Woodford	Members: 9-Dist. 2	Ronald L. Meyer 401 N. Main St., Roanoke 61561	Ronald L. Meyer 401 N. Main St., Roanoke 61561

No Organized County Society: Cass-Brown, Edwards, Johnson, Menard

Joint County Societies: Alexander-Pulaski; Coles-Cumberland; Henry-Stark; Jefferson-Hamilton; Jersey-Calhoun; Marshall-Putnam; Morgan-Scott; Saline-Pope-Hardin; Will-Grundy.

ISMS House of Delegates

Official Members of the House with the right to vote

Officers of ISMS

President—Harry A. Springer, 800 Austin St., Suite 610, Evanston 60202
President-Elect—Eugene P. Johnson, 520 S. Second St., Apt. 403, Springfield 62701
First Vice-President—Pedro A. Poma, 675 W. North Ave., Suite 407, Melrose Park 60160
Second Vice-President—Donald K. Rokosch, 800 N. Logan, Suite 104, Danville 61832
Secretary-Treasurer—Boyd E. McCracken, Sr., Health Care Drive, Rural Rt 3, Box 40, Greenville, 62246

House of Delegates

Speaker—Robert M. Reardon, 1008 N. Main St., Bloomington 61701
Vice Speaker—Joan E. Cummings, Extended Care, Bldg. 1, Room C, 124-D, 181 Hines VA Hospital, Hines, IL 60141

Board of Trustees

Chairman, Board of Trustees—Harold L. Jensen, Ingalls Memorial Hospital, One Ingalls Dr., Harvey 60426
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2nd District—Ross N. Hutchison, 126 E. 9th St., P.O. Box 388, Gibson City 60936 1989
3rd District—James H. Andersen, 141 Breakenridge Farm, Oak Brook 60521 1989
H. Constance Bonbrest, Univ. of Illinois College of Medicine, 1737 W. Polk, Bldg AOB Room 414, Chicago 60612. 1990
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Audley F. Connor, Jr., Jackson Park Hospital, 7531 S. Stony Island Ave., Chicago 60649 1989
Ulrich F. Danckers, 1040 Monroe Ave., River Forest 60305 1991
Harold L. Jensen, Ingalls Memorial Hospital, One Ingalls Dr., Harvey 60428 1991
M. Anita Johnson, 8620 W. 93rd Place, Hickory Hills 60457 1990
William J. Marshall, 2601 Lincoln Hwy., Olympia Fields 60461 1991
Adriano S. Olivar, St. James Hosp., Dept. of Pathology, Chicago Rd. & Lincoln Hwy., Chicago Heights 60411 1990
Robert M. Vanecko, 6200 N. Kilpatrick Ave., Chicago 60646 1990
4th District—Lorris M. Bowers, 214 NE Glen Oak, Suite 600, Peoria 61603 1991
5th District—Michael C. Snyder, St. John's Hosp., Dept. of Radiology, 800 E. Carpenter St., Springfield 62702 1989
6th District—George T. Wilkins, Jr., #1 Glen Ed Prof. Park, Edwardsville 62025 1990
7th District—Alfred J. Kiessel, St. Mary's Hospital, Dept. of Pathology, 1800 East Lake Shore Dr., Decatur 62521 1991
8th District—Arthur R. Traugott, 1107 Eliot Dr., Urbana 61801 1989
9th District—Phillip D. Boren, Doctor's Clinic, South Plum St., Carmi 62821 1990
10th District—Ronald G. Welch, 333 S. Illinois, Suite B, Belleville 62220 1990
11th District—Raymond A. Dieter, Jr., 22 W. 240 Stanton Rd., Glen Ellyn 60137 1989
12th District—Raymond E. Hoffmann, 1030 Highview Ave., Rockford 61107 1989
Trustee-At-Large—Edward J. Fesco, 208 Marquette St., LaSalle 61301 1989

AMA Delegation Chairman, *Ex-Officio*—Robert C. Hamilton, 711 W. North Ave., Chicago 60610

ISMIE Board of Governors Chairman, *Ex-Officio*—Fred Z. White, P.O. Box 279, 525 Sweetbriar, Chillicothe 61523

ISMIS Board of Directors Chairman, *Ex-Officio*—Robert C. Hamilton, 711 W. North Ave., Chicago 60610

Ex-Officio Members of the House without the right to vote

Past Presidents

Herschel Browns* 1981
Edward W. Cannady* 1970
Newton DuPuy* 1968
Edward J. Fesco 1987
David S. Fox* 1979
Jere E. Freidheim* 1987
Robert C. Hamilton* 1985
J. M. Ingalls 1976
Charles J. Jannings, III 1972
Frank J. Jirka, Jr.* 1973
Robert P. Johnson* 1984
Fredric D. Lake* 1975
Morgan M. Meyer 1986
Willard C. Scrivner* 1974
P. John Seward* 1980
Joseph H. Skom* 1977
Leo P. A. Sweeney* 1953
Fred Z. White* 1982
Cyril C. Wiggishoff* 1983
George T. Wilkins, Jr. 1978

**Also a past trustee or councilor*

Past Speakers

Edward W. Cannady, Belleville 1965-1968
Maurice M. Hoeltgen, Chicago 1968-1970
Paul W. Sunderland, Gibson City 1970-1973
Andrew J. Brislen, Chicago 1973-1975
James A. McDonald, Geneva 1975-1977
Cyril C. Wiggishoff, Chicago 1977-1979
Robert P. Johnson, Springfield 1979-1981
Clifton L. Reeder, Wilmette 1981-1983
Julian W. Buser, Belleville 1983-1985
Lawrence L. Hirsch, Northbrook 1985-1987

Ex-Officio Members of the House without the right to vote

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Julian W. Buser, Belleville, Trustee of the 10th District
Joan E. Cummings, Hines, Trustee of the 3rd District
Raymond DesRosiers, Chicago, Trustee of the 3rd District
Herbert Dexheimer, Belleville, Trustee of the 10th District
Alfred Faber, Northbrook, Trustee of the 3rd District
Robert T. Fox, Chicago, Trustee of the 3rd District
Morris T. Friedell, Chicago, Trustee of the 3rd District
Robert R. Hartman, Jacksonville, Trustee of the 6th District
Henrietta Herbolsheimer, Chicago, Trustee of the 3rd District
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Eugene Hoban, Chicago, Trustee of the 3rd District
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James Laidlaw, Champaign, Trustee of the 8th District
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Paul F. Mahon, Springfield, Trustee of the 5th District
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Thomas P. Meirink, Belleville, Trustee of the 10th District
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Joseph Perez, Rockford, Trustee of the 12th District
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Pedro A. Poma, Melrose Park, Trustee of the 3rd District
Robert L. Prentice, Springfield, Trustee of the 5th District
Ralph N. Redmond, Sterling, Trustee of the 2nd District
Clifton L. Reeder, Wilmette, Trustee of the 3rd District
John J. Ring, Mundelein, Trustee of the 1st District
Richard N. Rovner, Chicago, Trustee of the 3rd District
Joseph C. Sherrick, Chicago, Trustee of the 3rd District
Harry A. Springer, Evanston, Trustee of the 3rd District
Darrell H. Trumpe, Springfield, Trustee of the 5th District
Warren D. Tuttle, Harrisburg, Trustee of the 9th District
Frederick E. Weiss, Harvey, Trustee of the 3rd District
Charles K. Wells, Mt. Vernon, Trustee of the 9th District
Herman Wing, Chicago, Trustee of the 3rd District

ISMS Delegation to the AMA

Delegation Chairman: Robert C. Hamilton/Secretary: George T. Wilkins, Jr.

Delegates

To serve from Jan. 1, 1987 to Dec. 31, 1988 (Elected April 5, 1986)

James H. Andersen, Oak Brook
Audley F. Connor, Jr., Chicago
Joan E. Cummings, Chicago*
Lawrence L. Hirsch, Northbrook
Joseph R. O'Donnell, Glen Ellyn
Pedro A. Poma, Melrose Park
Richard Quinones, Chicago
P. John Seward, Rockford
Robert M. Vanecko, Chicago
Fred Z. White, Chillicothe
George T. Wilkins, Jr., Edwardsville

To serve from Jan. 1, 1988 to Dec. 31, 1989 (Elected April 12, 1987)

Alfred J. Clementi, Arlington Heights
Jere E. Freidheim, Chicago
Robert C. Hamilton, Chicago
Harold L. Jensen, Flossmoor
Alfred J. Kiessel, Decatur****
Morgan M. Meyer, Lombard
Harry A. Springer, Evanston
Arthur R. Traugott, Urbana
Ronald G. Welch, Belleville

To serve from Jan. 1, 1989 to Dec. 31, 1990 (Elected April 13, 1988)

James H. Andersen, Oak Brook
Joan E. Cummings, Chicago
Henrietta Herbolsheimer, Chicago
Gail Herman, Chicago
Lawrence L. Hirsch, Northbrook
Joseph B. Perez, Rockford
Pedro A. Poma, Melrose Park
P. John Seward, Rockford
Robert M. Vanecko, Chicago
Fred Z. White, Chillicothe
George T. Wilkins, Jr., Edwardsville

Alternates

To serve from Jan. 1, 1987 to Dec. 31, 1988 (Elected April 5, 1986)

Juanito S. Bartolome, Jr., Chicago
Scott Bernstein, Urbana
H. Constance Bonbrest, Chicago
Chester C. Danehower, Jr., Peoria*
Manuel O. Guerrero, Moline
Henrietta Herbolsheimer, Chicago
Alfred J. Kiessel, Decatur
Eugene B. Loftin, Elgin*
William J. Marshall, Chicago
Joseph B. Perez, Rockford

To serve from Jan. 1, 1988 to Dec. 31, 1989 (Elected April 12, 1987)

Randall T. Bellows, Chicago
Albino Bismonte, Gurnee
Claire M. Callan, North Chicago****
Ulrich F. Danckers, River Forest
Earl E. Fredrick, Jr., Chicago
Silvana Menendez, Belleville
Robert M. Reardon, Bloomington
Donald K. Rokosch, Danville
Joseph H. Skom, Chicago
M. LeRoy Sprang, Evanston

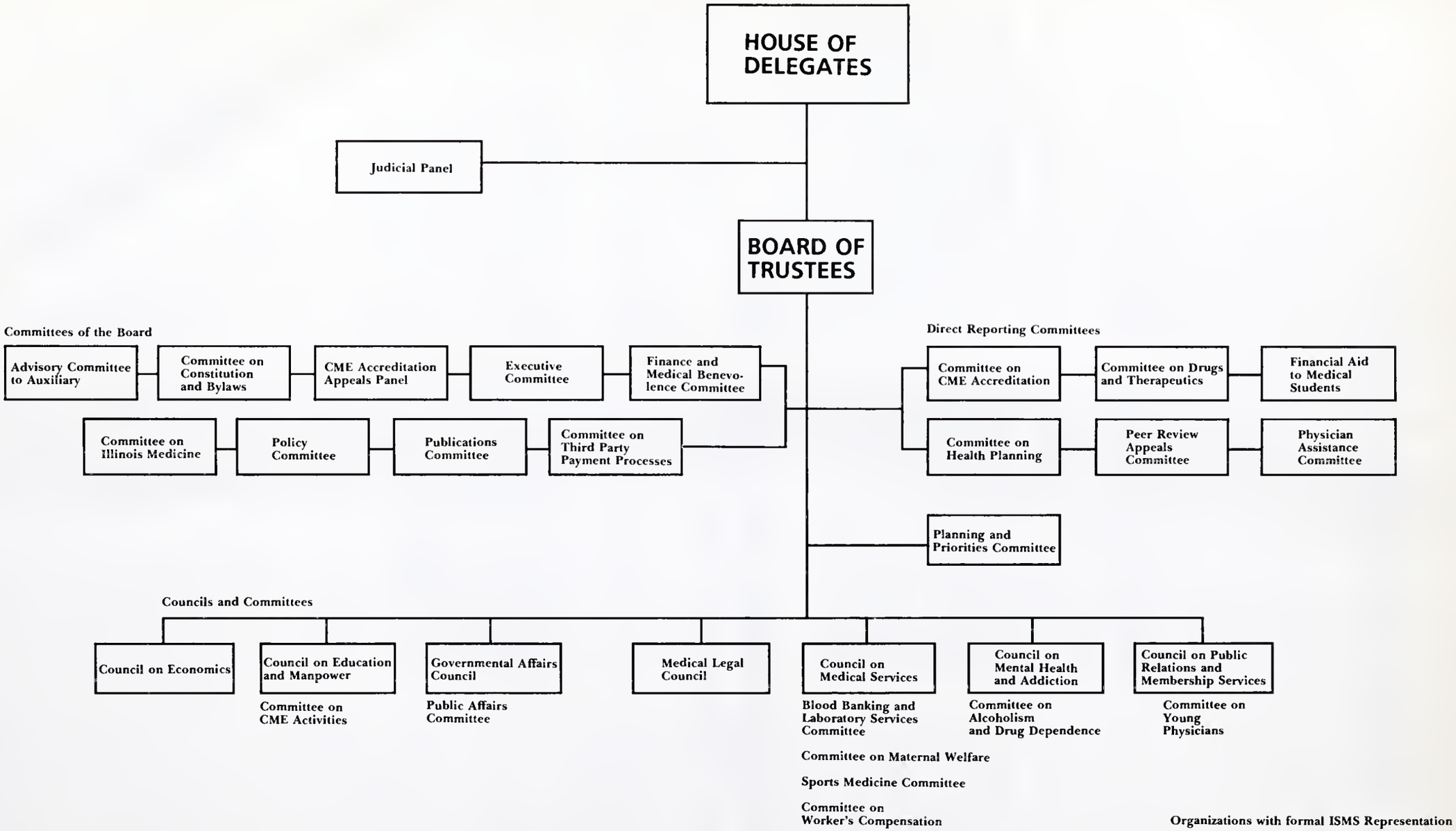
To serve from Jan. 1, 1989 to Dec. 31, 1990 (Elected April 13, 1988)

Juanito S. Bartolome, Jr., Chicago
Scott Bernstein, Urbana**
H. Constance Bonbrest, Chicago
Audley F. Connor, Jr., Chicago
Chester C. Danehower, Jr., Peoria
Edward J. Fesco, LaSalle***
Manuel O. Guerrero, Moline
Roger N. Klam, Carbondale
Eugene B. Loftin, Elgin**
William J. Marshall, Chicago

**Elected to 20th position April 12, 1987 to serve immediately and until Dec. 31, 1988*
***Elected April 12, 1987 to complete unexpired term until Dec. 31, 1988*
****Elected April 24, 1988 to complete unexpired term until Dec. 31, 1988*
*****Elected April 24, 1988 to complete unexpired term until Dec. 31, 1989*

Honorary Members

Frank J. Jirka, Jr., Barrington Hills; John J. Ring, Mundelein



Organizations Directly Related to ISMS

Illinois State Medical Benevolent Fund, Inc.
Illinois State Medical Insurance Services, Inc.
Illinois State Medical Inter-Insurance Exchange
ISMS Auxiliary
ISMS Educational and Scientific Foundation
ISMS Hospital Medical Staff Section
Medical Student Section
Resident Physician Section

Organizations with formal ISMS Representation

Ill. Society of Medical Assistants
Ill. Interagency Council on Smoking and Disease
Illinois Cancer Council
U.S. Pharmacopacia
Student Loan Fund Board, ISMS/IAA

Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board committees. Some free standing committees may report directly to the Board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the Board, as do representatives to various other agencies. The president, speaker of the House, and chairman of the Board are, by virtue of their office, *ex-officio* members of all groups.

COUNCIL ON ECONOMICS

Alfred J. Kiessel, Decatur, *Chairman*
James A. Bull, Silvis
Patrick E. Ebenhoeh, Chicago
Peter E. Friedell, Chicago
Robert C. Goff, Morris
Arvind K. Goyal, Itasca
William E. Kobler, Rockford
Joseph L. Murphy, Chicago
Ronald F. Pokornowski, Carol Stream
Norman J. Scheibling, Springfield
John F. Schneider, Chicago
Gerald E. Silverstein, Chicago

Illinois Chapter Of Amer. College of UR Physician Representative
Gerard R. Gnade, Jr., Harvey

Consultants
Raymond E. Hoffmann, Rockford
Pedro A. Poma, Melrose Park
Donald K. Rokosch, Danville
Robert M. Vanecko, Chicago
Fred Z. White, Chillicothe

Resident Representative
Amy B. Forman, Chicago

Student Representative
Jong Kook Kim, Chicago

Auxiliary Representative
Sherry Betsill (Mrs. Wesley), Springfield

Responsibilities and Purposes:

The Council on Economics considers issues that are of direct and immediate economic concern to the practice of medicine in Illinois. The Council is interested in effective practice management and the economic impact of governmental health care activities and policies, private health care initiatives, alternative health care delivery systems and the activities of the various utilization review agencies (*i.e.*, PRO, Foundations for Medical Care and private preadmission review initiatives). The Council analyzes the impact of these programs, both existing and proposed, and reports its recommendations to the Board of Trustees.

COUNCIL ON EDUCATION AND MANPOWER

Boyd E. McCracken, Sr., Greenville, *Chairman*
Francois Alouf, Chicago
Bruce C. Becker, Lombard
Michael A. Blood, Fairfield
Dean R. Bordeaux, Peoria
Daniel G. Cunningham, Chicago
Peter O. Fried, Lisle
Raza M. Khan, Waukegan
Morris A. Kugler, Belleville
Philip A. Lobo, Arlington Heights
Donald F. Pochyly, Chicago
Mitchell L. Rhodes, North Chicago
Stephen Schubert, Mendota

Consultants
H. Constance Bonbrest, Chicago
William J. Marshall, Olympia Fields

Resident Representative
Charles Terzian, Palos Heights

Student Representative
Dipali V. Apte, Urbana

Auxiliary Representative
Nancy Hoffmann, Rockford

IMGMA Representative
Steven R. Perrigo, Springfield

Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review allied health issues. It shall communicate with deans of medical schools and residency training programs recommendations from the viewpoint of the practicing physician. It shall advise the Illinois Dept. of Professional Regulation, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

Committees:

CME Activities

COMMITTEE ON CME ACTIVITIES

Peter O. Fried, Lisle, *Chairman*
Mohan C. Airan, Woodridge
Robert L. Bertrand, Rockford
Joseph L. Daddino, Barrington
Michael G. Feinzimer, Highland Park
Thomas R. Harwood, Chicago
Ronald L. Johnson, Pittsfield

Responsibilities and Purposes:

The Committee on CME Activities serves as the planning and approval body for the Society's continuing education activities. The committee is responsible for identifying educational needs of Illinois physicians, assisting ISMS councils and committees (as directed by the Board or if requested by a committee) in their educational activities, applying for and maintaining ACCME accreditation for ISMS programs, producing programs and materials for medical education directors, and evaluating the application and effectiveness of ISMS CME programs and products in meeting the needs of Illinois physicians.

GOVERNMENTAL AFFAIRS COUNCIL

Terry Mason, Chicago, *Chairman*
Frank O. Becker, Monee
Albino T. Bismonte, Gurnee
Laurence J. Gott, Hoffman Estates
Alec B. Hood, McLeansboro
Eugene B. Loftin, Elgin
Paul F. Mahon, Springfield
Albert W. Ray, Jr., Joliet
Biswamay Ray, Oak Brook
Erlo Roth, Hinsdale
Thomas C. Schrepfer, Urbana
LeRoy Sprang, Evanston
William Tansey, Downers Grove

Consultants
Alfred J. Clementi, Arlington Heights
Robert Reardon, Bloomington
Robert C. Hamilton, Chicago

Ronald G. Welch, Belleville
George T. Wilkins, Jr., Edwardsville

Auxiliary Representative
Mrs. Alfred (Norma) Kiessel, Decatur

Student Representative
William McDade, Chicago

Resident Representative
Andrew Basile, River Grove

Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Cooperate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Public Affairs

PUBLIC AFFAIRS COMMITTEE

Paul F. Mahon, Springfield, *Chairman*
Norman R. Brill, Olympia Fields
Ronald H. Deering, Champaign
Thomas M. Iannucci, Olympia Fields
Ronald K. McGregor, Decatur
Charles A. Neumann, Downers Grove
Jerome Weiskopf, Rockford

Auxiliary Representative
Mrs. (Alan) Pam Taylor, Danville

Consultant
George T. Wilkins, Jr., Edwardsville

Responsibilities and Purposes:

The Public Affairs Committee is responsible for educating physicians about the political process and encouraging political involvement. The Committee also provides educational material on issues of interest to physicians and promotes physician involvement in public affairs activity.

MEDICAL LEGAL COUNCIL

Geoffrey Bland, Springfield, *Chairman*
Susan Balter, River Forest
Richard Blankshain, Oak Park
Clair M. Callan, North Chicago
Philip H. Dennis, E. St. Louis
Jere Freidheim, Chicago
Alan R. Hirsch, Chicago
George B. Murphy, Marion
H. Larry Penning, Decatur
Warren H. Staley, Chicago
Shashi B. Upadhya, Moline

Consultants
James H. Andersen, Oak Brook
Lorris Bowers, Peoria
David Littman, Highland Park

Adriano Olivar, Chicago Heights
Arthur Traugott, Urbana

Resident Representative
John E. McConnell, Park Ridge

Student Representative
Michael Cantor, Champaign

Auxiliary Representative
Mrs. Wayne (Lynn) Kassel, Joliet

Responsibilities and Purposes:

The Council cooperates with all organizations interested in medico-legal problems and educates members of the profession in such affairs. In addition, the Council is concerned with standards of practice, licensure and quackery.

This Council maintains liaison with the Illinois State Bar Association and cooperates with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Evaluator Panel. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

COUNCIL ON MEDICAL SERVICES

James L. McGee, Bloomington, *Chairman*
James P. Ahstrom, Downers Grove
E. Richard Blonsky, Chicago
Robert E. Einhorn, Olney
Anthony Galloway, Belleville
Ron W. Lee, Chicago
H. Bates Noble, Barrington
Richard J. Sassetti, Chicago
Stephen H. Sheldon, Chicago
Peter J. Soto, Belleville
Edward Wilt, Crystal Lake

Consultants:
Lorris Bowers, Peoria
Audley Connor, Chicago
Harold Jensen, Harvey
Michael Snyder, Springfield

Student Representative
James Rising, Oak Park

Resident Representative
Joel M. Press, Chicago

Auxiliary Representative
Cindy McLean (Mrs. John), Peoria

IDPH Representative
Director Bernard Turnock, M.D., Springfield

Responsibilities and Purposes:

The Council considers a broad range of issues and programs related to medical facilities, professional health education, public health, laboratory services and services for the disadvantaged. Specific interest areas include nutrition, hospital-medical staff relations, emergency medical services, maternal and child welfare, workers' compensation, sports medicine, and penal health care services.

Committees:

Blood Banking and Laboratory Services
Maternal Welfare
Sports Medicine
Workers' Compensation

COMMITTEE ON BLOOD BANKING AND LABORATORY SERVICES

Richard J. Sassetti, Chicago, *Chairman*
Robert E. Carlovsky, Rockford
John G. Dietrich, Springfield
Marshall Short, Chicago
Peter J. Soto, Belleville
R. Bruce Wellman, Urbana
Thomas Wiltbank, Peoria

Consultants:
Fazlur R. Khan, Oak Brook
Adriano Olivar, Chicago Heights
Mark A. Shima, Downers Grove
William G. Troyer, Chicago

Responsibilities and Purposes:

The Committee considers issues and programs pertaining to medical laboratories, blood banking, and related areas affecting the practice of medicine in Illinois; handles matters brought to its attention by the Council on Medical Services; reviews matters related to standards of practice and provides guidance on improving patient care provided via medical laboratories, blood banks, and related entities; works with state agencies on matters relating to medical laboratories, blood banks, and related areas; and oversees ISMS direction to support the provision of blood transfusion services that meet the needs of the patients throughout Illinois, via coordinating activities and discussions with blood banks.

COMMITTEE ON MATERNAL WELFARE

District Members and Alternates
(alternates in italics)

1. Jack M. Miller, Aurora
Harry Burstein, Highland Park
2. Carl P. Mattioda, Streator
Leo Wrona, Joliet
3. Linda Holt, Wilmette
4. Robert Westefer, Peoria
Jeffrey N. Maurus, Moline
5. Robert C. Kaufman, Springfield
Thomas M. O'Hern, Springfield
6. Lemuel G. Villanueva, Jacksonville
Alan Skirball, Granite City
7. William L. Wagner, Decatur
8. Kathleen T. LeVeck, Mattoon
9. Cynthia Fraed, Harrisburg
10. Steven Mathus, Belleville
Casimiro C. Garcia, Jr., Belleville
11. Thomas R. Eckman, Downers Grove
Roger DeCook, Downers Grove
12. John E. Tillis, Rockford

Consultants:
Robert R. Hartman, Jacksonville
John Louis, Lake Forest
Augusta Webster, Chicago
Ed Ryan, Palos Park
Bernard Turnock, IDPH, Springfield
Diana Mertens, Springfield
Richard Gelfand, Evanston

Responsibilities and Purposes:

The primary responsibility of this committee is to review cases of maternal mortality in Illinois. This function is performed under a contract with the state health department. The Committee also deals with issues involving maternal health services and perinatal care.

SPORTS MEDICINE COMMITTEE

H. Bates Noble, Barrington, *Chairman*
Daniel Adair, Springfield
Craig Dean, Libertyville
Henry J. Dold, Arlington Heights
Richard J. Dominguez, Carol Stream
Jeffrey Gilles, Rockford
John A. Hefferon, Chicago
Merle H. Muller, Fairfield
Dennis J. Stanczyk, Belleville
Preston Wolin, Chicago

Consultant:
Robert C. Hamilton, Chicago

Responsibilities and Purposes:

The committee conducts programs aimed at improving the recognition and treatment of athletic-related injury and disease; advises junior and senior high school coaches and trainers; works with other groups and organizations involved in sports medicine activities; and provides overall direction to the ISMS Physician Games.

COMMITTEE ON WORKERS' COMPENSATION

E. Richard Blonsky, Chicago, *Chairman*
Nicholas C. Caro, Chicago
Dominick S. Renga, Highland Park
Alberto E. Rodriguez, Oak Park
Jay V. Subbarao, Hines

Responsibilities and Purposes:

The committee reviews how physicians are involved and affected by the workers' compensation system in Illinois.

COUNCIL ON MENTAL HEALTH AND ADDICTION

Thomas Minogue, Urbana, *Chairman*
Fern E. Asma, Park Ridge
Ronald Kirschner, Glenview
Earl Loschen, Springfield
P.S. Sarma, Chicago
Thomas T. Tourlentes, Galesburg
James D. Wright, Joliet

Consultants:
Audley Connor, Chicago
M. Anita Johnson, Chicago
Michael Snyder, Springfield

Student Representative
Robert Stephen Callaghan, Chicago

Auxiliary Representative
Pat Spadoni, Willow Brook

IDMH/DD Representative
Edward Page-El, M.D., Chicago

Responsibilities and Purposes:

This council serves as a source of information on mental health matters for ISMS. The council cooperates with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse. It is also concerned with reviewing legislation and regulations related to these fields and provides direction for the ISMS Substance Abuse Education program.

Committee:

Alcoholism and Drug Dependence

COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

Ronald Kirschner, Glenview *Chairman*
Sam Gaines, Springfield
David Spencer, Springfield
Ruth Wharton, River Forest

Consultants:
Roalda J. Alderman, Dept. of Alcoholism and Substance Abuse

Daniel Behnke, Dept. of Alcoholism and Substance Abuse

IMGMA Representative
Barbara Thomas, Chicago

Auxiliary Representative
Darlene Stevenson, Quincy

Responsibilities and Purposes:

The committee works closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs.

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Jane Jackman, Springfield, *Chairman*
Silvana Y. Menendez, Belleville
Morgan M. Meyer, Lombard
Sandra J. Olson, Chicago
Stanley G. Rousonelos, Joliet
William B. Spriegel, Evanston
John M. Sultan, Glencoe
Lloyd E. Thompson, Belleville

Consultant Trustees
Ulrich F. Danckers, River Forest
Edward J. Fesco, LaSalle

Harry A. Springer, Evanston

Consultant County Executives
Fred Schwartz, Chicago

Resident Representative
Rashid Soofi, Chicago

Auxiliary Representative
Laura Hays, Kankakee

Student Representative
JoAnne Micale, Chicago

IMGMA Representative
John Robertson, Springfield

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance relationships between the media, public and members of the medical profession; and to retain and recruit members in the Society.

Committee

Young Physicians

COMMITTEE ON YOUNG PHYSICIANS

John M. Sultan, Glencoe, *Chairman*
Michael Davidson, Oak Park
Tim Kisabeth, Alton
Alan M. Roman, Flossmoor
Michael R. Silver, Oak Park

Resident Representative
Judith L. Peters, Springfield

Responsibilities and Purposes:

The Committee addresses the unique, specific and pressing needs of young physicians.

Committees of the Board of Trustees

ADVISORY COMMITTEE TO ISMS AUXILIARY

Edward J. Fesco, LaSalle, *Chairman*
Harry A. Springer, Evanston
Harold L. Jensen, Harvey

Responsibilities and Purposes:

The Committee shall consist of the immediate past president as chairman, the president, and the chairman of the Board. The Committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members. It shall also monitor the services provided by ISMS to the Auxiliary.

COMMITTEE ON CONSTITUTION AND BYLAWS

Robert M. Reardon, Bloomington, *Chairman*
Joan E. Cummings, Hines
M. Anita Johnson, Chicago
David B. Littman, Highland Park
Michael C. Snyder, Springfield

Responsibilities and Purposes:

The Committee on Constitution and Bylaws shall:

1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;

2) Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and

3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

CME ACCREDITATION APPEALS PANEL

H. Constance Bonbrest, Chicago
Audley F. Connor, Jr., Chicago
Ulrich F. Danckers, River Forest
Raymond A. Dieter, Jr., Glen Ellyn
Ross N. Hutchison, Gibson City
Pedro A. Poma, Melrose Park
Ronald G. Welch, Belleville

Responsibilities and Purposes:

In the event the Committee on CME Accreditation makes a non-accreditation decision to an Illinois CME sponsor, the sponsor may make a formal appeal to this hearing committee, which, in turn, will make a formal recommendation to the ISMS Board of Trustees on the sponsor's application.

EXECUTIVE COMMITTEE

Harold L. Jensen, Harvey, *Chairman*
Alfred J. Clementi, Arlington Heights
Edward J. Fesco, LaSalle
Eugene P. Johnson, Springfield
Alfred J. Kiessel, Decatur
Boyd E. McCracken, Sr., Greenville
Pedro A. Poma, Melrose Park
Harry A. Springer, Evanston

Ex Officio (without vote)
Robert C. Hamilton, Chicago
Robert M. Reardon, Bloomington
Fred Z. White, Chillicothe

Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer and the trustee-at-large. The immediate past chairman of the Board shall be a member, provided he is still a Trustee. If the immediate past chairman is no longer a Trustee, the chairman of the Policy Committee shall serve on the Executive Committee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, the chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange and the chairman of the Board of Directors of the Illinois State Medical Insurance Services, Inc., and the speaker of the House of Delegates, or the vice speaker in his absence, shall serve as ex-officio members of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

FINANCE AND MEDICAL BENEVOLENCE COMMITTEE

Alfred J. Clementi, Arlington Heights, *Chairman*
Raymond E. Hoffmann, Rockford
Boyd E. McCracken, Sr., Greenville
Robert M. Vanecko, Chicago

Auxiliary Representative
Mrs. Pat Spadoni, Willow Brook

Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the Society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

COMMITTEE ON ILLINOIS MEDICINE

Joan E. Cummings, Hines, *Chairman*
H. Constance Bonbrest, Chicago
Phillip D. Boren, Carmi
Edward J. Fesco, LaSalle
Raymond E. Hoffmann, Rockford
Ronald G. Welch, Belleville
Fred Z. White, Chillicothe

Responsibilities and Purposes:

The Committee on Illinois Medicine has overall responsibility for the content and direction of *Illinois Medicine*. The physician members provide editorial guidance and make decisions on matters of policy.

POLICY COMMITTEE

Ronald G. Welch, Belleville, *Chairman*
Joan E. Cummings, Hines
Alfred J. Kiessel, Decatur

Responsibilities and Purposes:

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall annually review all policy statements adopted five or more years previously and incorporate suggestions for revisions and deletions into resolutions for approval by the Board of Trustees and introduction in the House of Delegates. It shall also make recommendations for future policy by Board resolution to the House.

PUBLICATIONS COMMITTEE

William J. Marshall, Olympia Fields, *Chairman*
Raymond A. Dieter, Jr., Glen Ellyn
Adriano S. Olivar, Chicago Heights
Michael C. Snyder, Springfield
George T. Wilkins, Jr., Edwardsville

Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editorial board in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, shall review all new accounts prior to acceptance and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

IMJ Editorial Board

Larry C. Gunn, Hinsdale
Eugene J. Rogers, Chicago
Constantine S. Soter, Northbrook
David E. Trachtenbarg, Peoria
Donald D. VanFossan, Springfield
Edward A. Wolpert, Chicago

THIRD PARTY PAYMENT PROCESSES COMMITTEE

Arthur R. Traugott, Urbana, *Chairman*
James H. Andersen, Oak Brook
Lorris M. Bowers, Peoria
Audley F. Connor, Jr., Chicago
David B. Littman, Highland Park

ISIM Representative
Donald E. Casey, Jr., Oak Park

Responsibilities and Purposes:

The Committee on Third Party Payment Processes is a committee of the Board of Trustees. Its primary responsibility is to interact with the appropriate governmental and private third party reimbursement agencies on matters that require a role at the Board level. It monitors the activities of the Illinois Department of Public Aid, the Medicare program in Illinois, the CHAMPUS program in Illinois, Blue Cross/Blue Shield, other private insurers and other appropriate agencies whose problems have a significant impact on physician reimbursement. This committee reviews the policies of these organizations and makes appropriate recommendations to the Board of Trustees.

Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

COMMITTEE ON CME ACCREDITATION

Dean R. Bordeaux, Peoria, *Chairman*
Maruti S. Bhorade, Elmhurst
Patrick C. Cunningham, Rock Island
Ernesto B. Eusebio, Springfield
David Ginsburg, Highland Park
William T. Gogan, Summit
Julius S. Newman, Aurora

CONSULTANTS:
Ross N. Hutchison, Gibson City
David B. Littman, Highland Park
Boyd E. McCracken, Sr., Greenville
Robert M. Vanecko, Chicago

Responsibilities and Purposes:

The committee adopts necessary procedural rules and prescribes forms to be used in the conduct of CME accreditation. It reviews applications and survey team reports for intrastate CME sponsors, and makes decisions on the granting of initial accreditation and continuation of accredited status.

Accreditation Activities

ISMS is approved by the Accreditation Council on Continuing Medical Education to accredit intrastate CME sponsors. An integral part of the program is the site visit, used to gather materials, document and verify that the applicant has met the essentials for accreditation.

Physicians throughout the state, including members of the Board of Trustees, councils, committees and medical educators, function as survey team members to gather the necessary information, interview appropriate individuals and observe local CME activities. The Survey Site Team then makes recommendations to the ISMS Committee on CME Accreditation, which makes the final determinations for approval by the ISMS Board of Trustees.

CME Sponsors Accredited by the Illinois State Medical Society as of September 1, 1988

Alexian Brothers Medical Center, Elk Grove Village
Belleville Hospital Association for CME (Memorial Hospital, St. Elizabeth Hospital), Belleville
Carle Foundation Hospital, Urbana
Central Community Hospital, Chicago
Central DuPage Hospital, Winfield
Christ Hospital, Oak Lawn
Copley-Mercy CME Consortium, Aurora
Edgewater Hospital, Chicago
Edward Hospital, Naperville
Elgin Mental Health Center, Elgin
Elmhurst Memorial Hospital, Elmhurst
Forest Hospital, Des Plaines
Franciscan Medical Center, Rock Island
Glendale Heights Community Hospital, Glendale Heights
Good Samaritan Hospital, Downers Grove
Gottlieb Memorial Hospital, Melrose Park
Grant Hospital, Chicago
Highland Park Hospital, Highland Park
Hinsdale Sanitarium & Hospital, Hinsdale
Holy Cross Hospital, Chicago
Humana Hospital, Hoffman Estates
Illinois Masonic Medical Center, Chicago
Ingalls Memorial Hospital, Harvey
Institute for Psychoanalysis, Chicago
John F. Kennedy Medical Center, Chicago
Kishwaukee Community Health Center, DeKalb
Little Company of Mary Hospital, Evergreen Park
Louis A. Weiss Memorial Hospital, Chicago
Lutheran General—Lincoln Park, Chicago
Lutheran General Hospital, Park Ridge
MacNeal Memorial Hospital, Berwyn
Martha Washington Hospital, Chicago
Medical Center of Lake County, Libertyville
Mercy Hospital & Medical Center, Chicago
The Methodist Medical Center of Illinois, Peoria
Mount Sinai Hospital Medical Center, Chicago
Northwest Community Hospital, Arlington Heights
Norwegian-American Hospital, Chicago
Oak Forest Hospital, Oak Forest
Oak Park Hospital, Oak Park
Prairie Cardiovascular Center, Springfield
Ravenswood Hospital Medical Center, Chicago
Resurrection Hospital, Chicago
Riveredge Hospital, Forest Park
Riverside Hospital, Kankakee
Rockford Memorial Hospital, Rockford
St. Anthony Hospital Medical Center, Rockford
St. Elizabeth's Hospital, Chicago
St. Francis Hospital, Evanston
Saint Francis Hospital Medical Center, Peoria
St. James Hospital, Chicago Heights
St. Joseph Hospital, Chicago
St. Joseph Hospital, Elgin
St. Mary's Hospital, Kankakee
St. Mary of Nazareth Hospital, Chicago
St. Therese Hospital, Waukegan
Sherman Hospital, Elgin
Springfield Clinic, Springfield
Swedish American Hospital, Rockford
Swedish Covenant Hospital, Chicago
United Samaritan's Medical Center, Danville
Westlake Community Hospital, Melrose Park
West Suburban Hospital, Oak Park

Accreditation Site Surveyors

The following individuals participate in accreditation activities by serving as site surveyors (all are physicians unless otherwise indicated):

Philip D. Anderson, M.D., Ph.D.
Bruce C. Becker
Robert L. Bertrand
Ben B. Blivaiss, Ph.D.
H. Constance Bonbrest
Dean R. Bordeaux, M.D., M.A.
Lorris M. Bowers
Bradford W. Claxton, M.Ed.
Alfred J. Clementi
Joan E. Cummings
Joseph L. Daddino
Raymond A. Dieter, Jr.
Richard E. Dukes
Peter O. Fried
Linda K. Gunzburger, Ph.D.
Terry F. Hatch
Henri Havdala
Thomas O. Henderson, Ph.D.
Lawrence L. Hirsch
Eugene T. Hoban
Ross N. Hutchison
Harold L. Jensen
Frank J. Jirka, Jr.
Eugene P. Johnson
M. Anita Johnson
Marten M. Kernis, Ph.D.
Howard B. Levy
David B. Littman
Pedro Lopez
William J. Marshall
Paul A. Maxwell, Jr.
Boyd E. McCracken, Sr.
Harold Paul
Thomas G. Pearson, Ed.D
Joseph B. Perez
Ward E. Perrin
Pedro A. Poma
Donald F. Pochyly
Anthony Sapienza
Joseph C. Sherrick
Francis H. Straus, II
Jacob R. Suker
L.W. Tanner
Sheldon S. Waldstein
Fred Z. White, M.D., M.A.
Roger A. Wujek
William H. Young, Ed.D.
Simon Zivin

COMMITTEE ON DRUGS AND THERAPEUTICS

Vincent A. Costanzo, Jr., Chicago, *Chairman*
Lawrence L. Hirsch, Northbrook
Theodore M. Kanellakes, Joliet
Armand Littman, Evanston
Allan L. Lorincz, Chicago
Patrick R. Staunton, Oak Park

Consultants:
Phillip O. Boren, Carmi
Joan E. Cummings, Hines

IDPA Representative:
Dawn Gottrich, Springfield

IPHA Representative:
Sam Enloe, Jr., R.Ph., Decatur

Responsibilities and Purposes:

The committee meets periodically to review the listing of pharmaceutical products in the IDPA Drug Manual. When it deems it necessary to recommend new products for inclusion or deletion of covered products from the Manual, the committee shall request the Board of Trustees to approve and forward its recommendations to the Illinois Department of Public Aid. Comments or suggestions made by the membership regarding drug products also are reviewed by the committee.

COMMITTEE ON FINANCIAL AID TO MEDICAL STUDENTS

Fred Z. White, Chillicothe, *Chairman*
George Beranek, Chicago
Edward J. Fesco, LaSalle
Jere E. Freidheim, Chicago
Morgan M. Meyer, Lombard
Karl W. Scheribel, Arlington Hts.

Student Representative
Andrew Chenelle, Chicago

Responsibilities and Purposes:

The Committee on Financial Aid to Medical Students shall be responsible for developing and maintaining a student loan program through the Educational & Scientific Foundation to assist Illinois medical students in meeting financial obligations of an undergraduate medical school program. In particular, this Committee shall explore ways and means of raising funds for the development of a student loan program and, through the ISMS Educational and Scientific Foundation, establish guidelines and administration for such a program.

COMMITTEE ON HEALTH PLANNING

Henrietta Herbolsheimer, Chicago, *Chairman*
Martin E. Bruetman, Palos Heights
Roman I. Filipowicz, South Holland
John W. Mason, Hinsdale
Albert J. Novotny, Peoria
Orlan W. Pflasterer, Coulterville

Consultants:
H. Constance Bonbrest, Chicago
Eugene P. Johnson, Springfield
Donald K. Rokosch, Danville

Auxiliary Representative:
Nancy Hoffmann, Rockford

Responsibilities and Purposes:

The Committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Health Facilities Planning Board and local planning agencies. The Committee also monitors health care coalitions in Illinois and reports to the Board on coalition activities.

PEER REVIEW APPEALS COMMITTEE

Boone Brackett, Oak Park, *Chairman*
Randy Bellows, Chicago
William J. Dougherty, Moline
Earl Fredrick, Chicago
Henri S. Havdala, Lincolnwood
Donald Pearson, Springfield

Responsibilities and Purposes:

This committee serves as the appellate body for cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relations issues. The committee is the state society's liaison to local peer review committees and monitors review activities around the state.

PHYSICIAN ASSISTANCE COMMITTEE

L. Michael Newman, Evanston, *Chairman*
Daniel Angres, Lombard
Ira M. Brent, Decatur
Warren A. Clohisy, Jr., Chicago
Elmer E. Crisp, Jr., LaGrange
Thomas T. Flynn, Mt. Vernon
Charles Frazer, Jr., E. St. Louis
Lee Gladstone, Chicago
Thomas Krizek, Chicago
James Leonard, Champaign
Richard L. Newman, Quincy
Pola J. Piotrowski, Barrington
Eduardo Ricaurte, Moline
Edward Sutoris, Chicago
Herbert Trace, Evanston
James West, Inverness

Resident Representative:
Debra Klamen, Chicago

Consultants:
H. Constance Bonbrest, Chicago
Raymond Dieter, Jr., Glen Ellyn
Violet M. Eggert, Chicago
Michael C. Snyder, Springfield

Student Representative:
R. Steven Callaghan

Responsibilities and Purposes:

The Committee consists of physicians who provide assistance to impaired physicians and those concerned about them for problems related to alcohol or drug dependence, physical disabilities, mental or emotional disturbances. The Committee provides information, sponsors educational programs, offers counseling, conducts interventions, provides monitoring and serves as the recovering physician's advocate. All activities are provided in a confidential and professional manner.

PLANNING AND PRIORITIES COMMITTEE

Eugene P. Johnson, Casey, *Chairman*

Responsibilities and Purposes:

The president-elect shall serve as the chairman of the Committee on Planning and Priorities. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the president-elect in the formation of his objectives for accomplishment during his term as president.

Direct Reporting Committees of the House of Delegates

JUDICIAL PANEL COMMITTEE

	Term Expires
Daniel G. Cunningham, Riverside	1992
Arthur R. Fischer, Berwyn	1989
Jack L. Gibbs, Canton	1991
Robert H. Lund, Rockford	1990
Donald Morehead, Ottawa	1993

Responsibilities and Purposes:

The Panel, whose members are nominated by the President and elected by the House of Delegates, adjudicates disputes arising from charges of unethical or illegal practices. The panel accepts appeals after a case has been heard at the county or district level.

Other Appointments and Representatives

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Jack L. Gibbs, Canton, *Chairman*
David Dunn, Urbana
Randall Mullin, Geneseo
John Arnold, Bushnell (alternate)

Responsibilities and Purposes:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

ISMS REPRESENTATIVES TO OTHER GROUPS

Liaison to Ill. Soc. of Med. Assts.
Edward J. Fesco, LaSalle

Illinois Cancer Council
Peter E. Friedell, Chicago

Ill. Interagency Coun. on Smoking and Disease
Charles L. Swarts, Oak Park

U.S. Pharmacopaeia
Vincent Costanzo, Chicago, *Delegate*
Joseph Skom, Chicago, *Alternate*

ISMS SERVICES

Members of the Illinois State Medical Society benefit from a wide range of services, programs, and publications. These are developed in response to official actions and policies of the House of Delegates and implemented through the Board of Trustees. The headquarters staff has been structured to respond to the directives of the House and the Board and develops and coordinates activities to provide these services. Following is a brief description of the departmental structuring, organization and services of the Society and the headquarters office.

EXECUTIVE OFFICE

Mr. Alexander R. Lerner is executive vice president of the Society. The executive vice president is responsible for the implementation of established policy, fiscal, budgetary and personnel matters. In this position, the executive vice president:

- provides liaison with the Board of Trustees and implements their actions
- is responsible for support and staffing of the House of Delegates
- evaluates legal inquiries for appropriate referral to counsel
- has final authority for management team program planning and implementation
- provides guidance to officers, trustees, committee chairmen and county society officers
- directs activity and organization of staff personnel
- serves as secretary-treasurer for the Illinois State Medical Insurance Services, Inc.

Society programs, issues and activities are coordinated administratively through delegation of managerial authority.

ADMINISTRATION

The deputy executive vice president directs and manages activities of the Departments of Specialty Society Services and Administrative Records. Additionally, direct staff support is provided for the House of Delegates, Board of Trustees, Executive Committee, Policy Committee, Constitution and Bylaws Committee, the Educational and Scientific Foundation, the Medical Student Section and the Resident Physicians Section. Overall provision of services of staff are coordinated through the deputy executive vice president. The deputy executive vice president reports directly to the executive vice president and assumes additional responsibility at his direction.

Administrative Records

The Department of Administrative Records is charged with responsibility for maintaining the listing of official actions and positions taken by ISMS' House of Delegates and Board of Trustees. The minutes and official transcriptions are maintained by this department. In addition, records of all appointments and nominations are kept, as well as any other official documents.

Services to Specialty Societies

Administrative services are provided to specialty societies and affiliated groups on a cost-allocated basis by the Department of Specialty Societies. These include office management, meeting arrangements, membership promotion and record maintenance, newsletter publishing, coordination of committee work, dues collection and accounting services. The ISMS currently provides services to the Illinois Association of Ophthalmology, Inc., Illinois Dermatological Society, Illinois Orthopaedic Society, Illinois Chapter, American Academy of Pediatrics, Illinois Psychiatric Society, Illinois Radiological Society, Illinois Society of Anesthesiologists, Inc., Illinois Society of Inernal Medicine, Illinois Academy of Physician Assistants, Illinois Medical Group Management Association, and Illinois Society of Medical Assistants.

COMMUNICATIONS

Under direction of the vice president, communications, the membership, marketing, public relations, publications, travel and meeting services, and purchasing and office services activities are coordinated. Staff in these areas:

- provide information on a broad range of issues that affect physicians in their practices;
- provide information to the media and public on the position of ISMS on important medical issues;
- provide consultation and coordination to other ISMS departments in the area of membership mailings, and distribution of membership and public information;
- provide information and services to hospital medical staffs;
- retain, recruit, promote and process membership in organized medicine at the county, state and AMA levels;
- educate physicians on the professional liability climate in general, and on the value of the Exchange in particular;
- provide information and coordinate programs for risk management;
- provide staff support to the ISMS Hospital Medical Staff Section; and
- provide meeting, travel, purchasing and office services to members and staff.

Meeting and Travel Services

A number of programs and services are provided to Society members or sponsored for their benefit. These include the 50-

Year-Club, meeting services and travel programs.

- The 50-Year-Club consists of physicians who graduated from medical school more than 50 years ago. An annual luncheon gives these members an opportunity to renew friendships.
- ISMS meeting services include provision of services for assemblies of the House of Delegates and Board of Trustees. Councils and committees meet in the headquarters office.
- Society-sponsored travel programs enable members to enjoy luxury cruises and tours. Qualified tour agencies are screened for professional, non-regimented trips.

Publications

Staff of the Department of Publications work to provide information to the ISMS membership through various publications. Services include promotional design and layout, editorial and creative work.

The Society's communications program will take a new turn in January 1989, with the launch of a biweekly tabloid newspaper to be called *Illinois Medicine.*

Illinois Medicine is the end-product of exhaustive membership surveys, which determined that ISMS' constituents prefer a timely, concise, accessible publication which summarizes socioeconomic news of medicine across the state. This new publication will take the place of current materials produced by both the Illinois State Medical Society and Illinois State Medical Inter-Insurance Exchange.

ISMS staff assists specialty societies and other affiliate groups in producing their newsletters and other publications. Assistance also is provided to the ISMS Auxiliary in the publication of *Pulse of the ISMS Auxiliary.*

Activities of the Division are directed by the Society's Publications Committee, the *IMJ* Editorial Board and the Committee on *Illinois Medicine.* Additional publication production services are provided for subsidiary organizations.

Public Relations

The ISMS Public Relations Department provides information to news media representatives and the public on health care issues. Building the visibility and image of Illinois' medical profession is the department's overall goal. Its activities include regular, frequent development of:

- news releases and related media information voicing ISMS public policy views;
- speeches for use by Illinois physicians in making presentations to a variety of public audiences;
- "white papers," viewpoint essays and brochures on key health care issues;
- public service announcements for broadcast by Illinois radio and television stations; and
- public information resource materials for use by county medical societies.

On a daily basis, the Public Relations Department handles all ISMS media requests and monitors coverage of health care-related topics by Illinois media outlets. Staff is also available to conduct spokesperson training workshops for those physicians speaking out on behalf of ISMS. The department provides services and programming for the Council on Public Relations and Membership Services.

Purchasing and Office Services

Purchasing and Office Services includes the purchasing and distribution of all goods and services necessary for the staff to implement the policies of the Society. This Department provides printing services, office supplies, and mailing services, record retention and inventory services.

Office services includes building services for staff and physician meetings, mail, printing and supply services for the Society. Centralized purchasing is also under the office service function.

Risk Management and Policyholder Communications

Risk Management and Policyholder Communications provides staffing for the Hospital Medical Staff Section and Governing Council and risk management/ loss prevention and marketing services for members and policyholders.

EDUCATIONAL AND MEDICAL SERVICES

The Department of Educational and Medical Services, under direction of the vice president of educational and medical services, is responsible for initiating, supporting, monitoring and implementing activities related to CME accreditation, alcohol and drug addiction, aging, emergency medical services, blood banking, licensure and accreditation of health care facilities, physician licensure and discipline, school and child health, medical education, medical-legal issues, sports medicine, public health, mental health, peer review, ethics, laboratory services, physician recruitment and CME activities.

These responsibilities are carried out through the following activities:

- council and committee meetings, where physician members, and representatives of the medical students, residents and ISMS Auxiliary examine, debate and formulate ideas and recommendations for consideration by the ISMS Board of Trustees;
- development of educational materials and programs for the physician and his or her patients; and
- liaison activities with governmental, professional and lay organizations, to promote and defend ISMS policies, express concerns and educate others about issues important to physicians.

The Department of Educational and Medical Services also administers the following specialized programs:

- ISMS Physician Games, where physicians and spouses compete in athletic competitions;
- The Substance Abuse Education Program, funded by a grant from the Illinois Department of Alcoholism and Substance Abuse, which produces educational materials and seminars to assist physicians in recognizing and treating substance abuse in their patients;
- Maternal morbidity and mortality reviews, funded by a grant from the Department of Public Health;
- ISMS Student Loan Fund Programs, directed by the Committee on Financial Aid to Medical Students, and funded by the contributions to the Educational and Scientific Foundation;
- Physician Assistance Program, which provides assistance to medical staffs, impaired physicians and their families in situations where alcohol, drugs, senility, disability or other problems prevent a physician from functioning;
- The Physician Support Group, which provides assistance to physician families in dealing with the confusion and stress accompanying involvement in a malpractice action; and
- The Physician Help Line, a confidential phone service, which connects troubled physicians and their families with the above mentioned services and resources.
- The Physician Recruitment Program seeks to link communities in need of a physician with those seeking practice opportunities.

These and other programs and services are available to ISMS members by calling or writing to the Department at the ISMS offices.

FINANCE

Financial Management services are conducted under policies established by the Board of Trustees and Finance Committee.

These activities include:

- financial reporting;
- maintaining financial records for receipts and disbursements;
- budgeting;
- monitoring investments;
- securing assets; and
- maintaining liaison with the various auditing firms.

GOVERNMENTAL AFFAIRS

The Department of Governmental Affairs, under direction of the vice president for governmental affairs, provides staff services for the Governmental Affairs Council, Public Affairs Committee, IMPAC, Field Services and liaison to various governmental agencies. The Society's legislative program is conducted under direction of the Governmental Affairs Council. All state and national health legislation is monitored. Society staff forward bills to physician members with pertinent expertise for review and comment. Legislative representatives express the ISMS position to legislators, while also continually monitoring amendments to bills of interest to the medical profession. The Department also coordinates physician testimony before legislative committees.

Additional input and citizen involvement are developed through the Key Contact Program, public affairs activity and *On the Legislative Scene.*

- The Key Contact Program is a network of physicians or spouses who are relatives, friends or campaign supporters of Illinois legislators, who advise legislators on health legislation.
- Public Affairs activity includes sponsorship of speakers at Society meetings and liaison with government agencies. It encourages grassroots involvement in the political process. Also, the Department coordinates activities of the Illinois State Medical Society Political Action Committee.

Field Services

Staff in this area:

- provide assistance and information to ISMS members on a broad range of issues by working with district trustees, county medical society leaders and executives, hospital medical staff leaders and ISMIE Network Representatives;
- coordinate the ISMS President's Tour, in which the president visits county medical society meetings and local media to discuss Society views and activities;
- promote and assist member activity to further ISMS legislative and governmental goals, including participation in IMPAC and the Key Contact program.

Staff services are provided through both the Chicago headquarters and the Springfield regional office.

HEALTH CARE FINANCE

Under the direction of the Vice President for Health Care Finance, the Department of Economics and the Department of Health Policy Research are involved in developing programs, policies, services and strategies to address the economic issues impacting the profession. Staff services are provided to the Council on Economics, the Committee on Third Party Payment Processes, the Committee on Health Planning and the Committee on Drugs and Therapeutics. Services are provided to members with questions or problems concerning health care economic issues and research.

Additionally, staff in this area maintain liaison with all appropriate professional associations and ancillary health economic organizations.

Staff in this area provide the following specific services:

Economics

- Medicaid, Medicare & CHAMPUS—Services are provided in representation of member interests of a policy nature. Liaison is provided with the Illinois Department of Public Aid and the Medicare Part B carrier to assure that member concerns are represented when policy issues are considered. Specific assistance is provided for members with inquiries about third party payer policies.
- Health Planning—Actions of the Illinois Department of Public Health, Illinois Health Facilities Planning Board, and local planning agencies are closely monitored and Society positions expressed.
- Third Party Payer and Economic Activity—The Department is directly involved in liaison activities with insurance carriers and government bodies on all economic issues relating to the practice of medicine. The Department performs research, offers speakers and monitors the development of new reimbursement and health care delivery systems for the membership, *e.g.,* Diagnosis Related Groups (DRGs), Preferred Provider Organizations (PPOs), Utilization Review (Private and Peer Review Organizations [PROs]) and HMOs/IPAs.
- Drugs and Therapeutics—The Department provides staff assistance to the ISMS Committee on Drugs and Therapeutics, which reviews new drug products and makes recommendations to the IDPA concerning recommended products for inclusion in and deletion from its Drug Manual for Public Aid recipients.

Health Policy Research

- Health Data Systems—Governmental requirements for statistical information on health care and planning are monitored and commented upon.
- Research Development—Rules and regulations proposed by various state code departments (IDPA, IDPH, DOI, CMS) and federal agencies (HCFA) are researched, monitored and commented upon to ensure that ISMS concerns about policies and procedures that impact

the practice of medicine are considered prior to implementation or adoption. The Department also reviews all pertinent Federal and Illinois Registers, and proposed legislation for possible comment and action, provides statistical analyses for the leadership on health economic issues, serves as a vehicle for health economic research and maintains liaison within the federation concerning development of various strategies on health economic issues (RVS, statewide IPA, HMO).

- Cost Containment—The cost containment activities of various health care entities are monitored, such as the activities of the Illinois Hospital Services Procurement Advisory Board and the Illinois Health Care Cost Containment Council. Additionally, the Department provides medical society comment and input on the activities and programs of the Illinois Health Care Cost Containment Council.

MANAGEMENT SERVICES

The Management Services department is responsible for the direction of computer services, human resources and facility management.

Computer Services

As an integral part of management, electronic data processing capabilities are maintained to provide a cost-effective method to:

- maintain membership and policyholder records;
- provide central Society dues billings and collection for county medical societies;
- provide invoicing for professional liability premiums;
- maintain records and statistics on professional liability claims, policyholder files and other insurance related information;
- process financial records;
- provide word processing capabilities; and
- provide and maintain telecommunication abilities as needed throughout the organization.

Facility Management

This area is responsible for management of the physical premises occupied by the Society and maintains liaison with the building management. This includes building services necessary for staff and physician meetings.

Human Resources

The responsibilities of Human Resources include recruitment and staffing, employee benefits program, payroll, employee evaluation and review program, maintenance of all personnel files and the administration of all employee services.

PLANNING AND PROGRAM DEVELOPMENT

The responsibilities of the associate executive vice president for planning and program development are designed to coordinate and execute a broad range of programs across departmental and organizational lines. These responsibilities include:

- provide staff support for the Planning & Priorities Committee and identification of major issues affecting physicians in their practice;
- develop programs that meet the informational needs of the physician membership and the public on the position of ISMS on important medical issues; and
- provide consultation and coordination to ISMS departments and affiliated organizations on planning and program development.

In addition, the associate executive vice president for planning and program development oversees and coordinates the activities of Professional Relations and Sponsored Insurance Programs.

Professional Relations

The Department of Professional Relations provides staff support for the Illinois State Medical Society Auxiliary, the Resident Physicians Section, the Medical Student Section, the Ad Hoc Committee on Young Physicians and the ISMS Benevolence Fund. It also provides additional support to the deputy executive vice president to the Illinois Delegation to AMA and to the associate executive vice president.

Sponsored Insurance Programs

Physicians' Benefits Trust

Recognizing that for many years the ISMS and the Chicago Medical Society offered the same types of benefit plans to some of the same physician members, the leadership of both organizations began to discuss combining the programs. During the course of this discussion it became evident that such a merger of the programs would benefit both the organizations and the physician members.

Therefore, in 1987 the ISMS merged its sponsored benefit insurance programs with those of the Chicago Medical Society. This merger resulted in what is now known as the Physicians' Benefits Trust, which offers benefit insurance plans to physician members throughout Illinois. R. T. Nelson and Associates, Inc., was named to administer the Physicians' Benefits Trust. At this same time a new Trust Board of Trustees was named, with the Chicago Medical Society appointing six members to the Board and the Illinois State Medical Society appointing three members.

As of July 19, 1988, the conversion from ISMS' prior insurance programs into the Physicians Benefits Trust was successfully completed. Insurance programs offered through the Trust are: Major Medical, Excess Major Medical, Medicare Supplement, Hospital Indemnity, Dental, Long Term Disability, Term Life, Accidental Death and Dismemberment, Personal Umbrella, and Office Overhead. Also offered is Group Practice Major Medical, Dental, Life and Disability. For further information or to enroll, members should contact the Physicians' Benefits Trust at 222 South Riverside Plaza, Suite 2360, Chicago, IL 60606 or call 312-559-9130. Please note that the Physicians' Benefits Trust does *not* provide professional liability insurance.

Worker's Compensation

The ISMS' sponsored Worker's Compensation Plan is administered under the Dodson Savings Plan. Policies are issued by the Casualty Reciprocal Exchange, a member of the Dodson Insurance Group. Specific aspects of the plan include: return declared at the end of each premium year on the basis of loss experience—savings are returned to policyholders; rates standard and approved for class of employment; and savings paid as earned within approximately 90 days of policy expiration or on completion of payroll audits.

DIRECTORY OF MANAGEMENT STAFF PERSONNEL

The Illinois State Medical Society headquarters office is located at Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602. The telephone number is (312) 782-1654. In addition, a Springfield office is maintained at 701 South Second Street, Springfield, Illinois 62704; telephone (217) 528-5609.

Below are the key staff identified by managerial areas in keeping with the above itemization of responsibilities. Following the name of the individual is a direct dial telephone number at the headquarters office. Any staff member can also be reached through the general information number (312) 782-1654.

EXECUTIVE OFFICE

Alexander R. Lerner, Executive Vice President 580-2412

ADMINISTRATION

Richard A. Ott, Deputy Executive Vice President 580-2460
Rose Anne Christiansen, Director, Administrative Records 580-2470
Leslie Davis, Director, Specialty Society Services 580-2480

COMMUNICATIONS

Linda Hudson, Vice President 580-2449
Suzanne W. Nelson, Assistant Vice President 580-2423
Elizabeth Duffy, Director, Meeting and Travel Services 580-2472
Mariann Stephens, Director, Publications 580-2419
Susan Wagner, Policyholder Services Coordinator 580-2463
Donald F. Perkowitz, Director, Purchasing and Office Services 580-2402

EDUCATIONAL AND MEDICAL SERVICES

Larry Boress, Vice President .. 580-2435
Violet Eggert, M.D., Medical Director, Physician Assistance Program 580-2445

FINANCE

Angela R. Walsh, Acting Director of Finance 580-2454

GOVERNMENTAL AFFAIRS

Jeffrey M. Holden, Vice President 580-2440
James Tierney, Assistant Vice President 580-2484
Daniel R. Nash, Field Representative 580-2411
Jill Funk, Field Representative 580-6459
Gordana Popovic, Political Education Coordinator 580-6441
Pam Blaum, Legislative Assistant 580-2443
Springfield Regional Office 217/528-5609

HEALTH CARE FINANCE

Robert K. Burger, Vice President 580-2462
Andrew Melczer, Director, Health Policy Research 580-2468
Ken Ryan, Director, Economics 580-2491
Elena Zukauskas, Staff Assistant 580-2416

MANAGEMENT SERVICES

Diana Role, Vice President, Management Services 580-2488
Carl Block, Director, Computer Services 580-2429

PLANNING AND PROGRAM DEVELOPMENT

Donald A. Udstuen, Associate Executive Vice President 580-2418
Cheryl Koos, Director, Professional Relations 580-2493

The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

I) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

The ISMS immediate past president serves as chairman of the Foundation's Board of Directors.

Board of Directors

Edward J. Fesco, LaSalle, *Chairman*
Harold L. Jensen, Harvey
Eugene P. Johnson, Springfield
Boyd E. McCracken, Sr., Greenville
Harry A. Springer, Evanston

Illinois Society of Medical Assistants

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society of Medical Assistants, an affiliate of AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending medical assistant programs are encouraged to join. Physician advisors at all three levels assist with educational endeavors.

The state society's numerous professional educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are: travel courses, regional seminars, annual symposium, and leadership seminars. The annual four-day meeting in April includes excellent lectures, study programs and the culmination of association business during the House of Delegates session.

The American Association of Medical Assistants encourages advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, administrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year. Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. For further information about this program contact the American Association of Medical Assistants, 20 North Wacker Drive Suite 1575, Chicago, Illinois 60606.

The president of the Illinois Society of Medical Assistants communicates via the "Executive Memo" (a monthly publication), with over 400 members giving pertinent information of current activities.

A quarterly publication "The Illini Cardinal" concentrates on education topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the Association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for nonmembers. There are many other benefits available (*i.e.*, group insurance). The AAMA Annual Meeting is held in the fall. It consists of educational programs, House of Delegates and other business meetings and tours of the hosting city.

Monthly educational meetings are scheduled in the following chapters: Cook County-Chicago (Downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), West Cook (River Grove), Cook County South (Oak Forest), Aux Plaines (Oak Park); DeKalb (Sycamore); LaSalle; Macon (Decatur); McLean (Bloomington); Peoria; Rock Island; St. Clair (Belleville) and Spoon River Valley (Canton). Physicians in these areas are asked to encourage their medical assistants to join the Association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

If there are no Illinois Society of Medical Assistants Chapters in your area, at-large memberships are still available. Information on the formation of new chapters and/or medical assisting can be obtained from Robin Bluestein, CMA-C, president, Illinois Society, 10471 Dearlove Road #1B, Glenview, IL 60025, Lucille Perce, CMA-C, Co-Chairman, Public Relations Committee, 22 W. 384 Teakwood Drive, Glen Ellyn, IL 60137 or Ehlma Garcia Mendez, CMA, EMT-A, Co-Chairman, Public Relations Committee, 5015 Briartree #311, Burbank, IL 60459.

Officers

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Vice Speaker of the House: Roxanne Steffens, CMA, Moline.
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Leslie Schwartz, Chicago
John L. Wright, Bloomington

Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services, Inc., is an Illinois corporation, formed in March, 1976, the capital stock of which is owned by the Illinois State Medical Society. It currently acts as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

The Inter-Insurance Exchange was organized as an insurance reciprocal to provide comprehensive professional liability insurance for Illinois physicians. Membership in the Exchange is limited to members of the Illinois State Medical Society. The Exchange is chartered under the laws of Illinois and functions under the Illinois Insurance Code.

Insurance Services provides management and underwriting services required for operation of the insurance business of the Exchange. It does so under Power-of-Attorney granted it by the Exchange in a management agreement and by each member of the Exchange through application for membership. Under the management agreement the Board of Governors of the Exchange prescribes policy to be followed in the conduct of the business. Within these policy guidelines Insurance Services provides management by accepting or rejecting applications, determining the form of insurance policies, and handling and disposing of claims. Insurance Services is compensated by the Exchange on the basis of expense reimbursement.

As a wholly-owned subsidiary, ISMIS provides certain services through ISMS on a shared basis. These shared services are on a direct cost reimbursement basis. Insurance Services includes the Divisions of Underwriting, Claims, Management Services and Internal Audit. In addition, shared services support is provided by ISMS through the Divisions of Administration, Communications, Educational and Medical Services, Governmental Affairs, and Finance.

Offices of Illinois State Medical Insurance Services, Inc., are at Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602; (312/782-2749).

Board of Directors

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Officers

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ISMS Auxiliary

The Illinois State Medical Society Auxiliary is an organization of physicians' spouses whose purpose is to help the medical profession in its endeavors to improve the health care and quality of life for all the citizens of Illinois. The auxiliary contributes to the ISMS Medical Student Loan Program, the ISMS Benevolence Fund, and to the American Medical Association Education and Research Foundation.

The Illinois State Medical Society Auxiliary had its inception in the parlor car of a speeding train in 1927. Dr. and Mrs. G. Henry Mundt were returning from the AMA meeting in Washington, D.C. and had learned of the existence of the AMAA and of 22 functioning state auxiliaries. Mrs. Mundt was persuaded to undertake the task of organizing an auxiliary in Illinois and to seek the approval of the Illinois State Medical Society's House of Delegates. On May 31, 1927, the ISMS House of Delegates endorsed the organization of an auxiliary in Illinois and urged the county societies to assist in promoting auxiliary membership.

The first formal meeting of the Auxiliary was held at the LeClaire Hotel in Moline on June 2, 1927, with 25 members present. In 1928, the organization became permanent. Sixty years later we have a membership of over 2,200 and we can look with pride at Auxiliary accomplishments.

We have striven to educate the public on cost effective benefits of preventive healthcare through all segments of our comprehensive Shape Up for Life program. The Auxiliary has instituted a large number of successful community health programs (*e.g.*, vial of life, nutrition, physical fitness, stress management, child seat belt safety, immunization, substance abuse awareness, teen suicide prevention, AIDS education, and adolescent sexuality). This year our health projects will focus on organ donation, problems facing the elderly, the fastest growing segment of our population, and adolescent substance abuse. A seminar dealing with the subject of volunteerism will also be presented. By educating our members at ISMSA sponsored workshops they are prepared to impart this knowledge within their communities.

The Auxiliary has been very active with legislation during the past year. It initiated the legislative internship program and has become quite knowledgeable in lobbying techniques. It also provides information on health-related legislation and is part of a legislative alert system. In an effort to have the Auxiliary expand activities in the area of support for the physician's family, it formed a family advocacy program to address family problems unique to the medical profession, including impairment and malpractice.

Being part of a federation allows us to attend national meetings for leadership training and education. We encourage our county presidents-elect to attend the AMAA sponsored Confluence. This three day in-depth training session is for future auxiliary leaders. All auxiliary members receive FACETS six times a year. This AMAA publication keeps members informed of issues facing medical families throughout the United States. They also receive PULSE, the quarterly publication of the ISMSA.

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Mrs. Raymond Hoffmann, Rockford
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Mrs. Luis Cespedes, Oak Brook
Mrs. Richard Newman, Quincy

Parliamentarian

Mrs. Harlan Failor, Champaign

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5. Mrs. Alfred Harney, Springfield
6. Mrs. Walter Stevenson, III, Quincy
7. Mrs. Stephen Chadwick, Decatur
8. Mrs. John Gapsis, Champaign
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10. Mrs. James Hull, Belleville
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AMA-ERF
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Archives
Mrs. Harlan Failor, Champaign

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Memorabilia
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Representatives to ISMS Councils & Committees

Committee on Alcoholism & Drug Dependence
Mrs. Walter Stevenson, III, Quincy
Benevolence
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Mrs. Wayne Kassel, Joliet
Medical Services
Mrs. John McLean, Peoria
Mental Health & Addiction
Mrs. Alex Spadoni, Willow Brook
Public Relations & Membership Services
Mrs. Philip Hays, Kankakee
Financial Aid to Medical Students
Not yet known

ISMS Hospital Medical Staff Section

Joseph L. Murphy, Chicago, *Chairman*
Silvana Y. Menendez, Belleville, *Vice-Chairman*
Charles R. Frazer, Jr., E. St. Louis, *Secretary*
Thomas C. Malvar, Chicago, *Treasurer*
Dennis M. Brown, Schaumburg, *Delegate*
Raymond A. Dieter, Jr., Glen Ellyn, *Alternate Delegate*
Albino T. Bismonte, Gurnee, *At-Large Member*
Ross N. Hutchison, Gibson City, *At-Large Member*
Jaroslav F. Neskodny, Berwyn, *At-Large Member*
John F. Schneider, Chicago *At-Large Member*

Responsibilities and Purposes

The Hospital Medical Staff Section shall provide representation of hospital medical staffs within the ISMS. The Section will also support the purposes of the ISMS, as stated in its Constitution. Membership in the Section consists of ISMS members who have been elected to represent their individual hospital medical staffs.

ISMS Medical Student Section

K. Gregory Lucchesi, *Chairman*
Simone Tizes, *Vice Chairman*
Mona Khanna, *Secretary*
Mary Wade Martin, *Delegate*
Robert Klem, *Alternate Delegate*
Kevin Tarrant, *Illinois MECO Director*

School Representatives

Chicago College of Osteopathic Medicine
Dan Miulli, Delegate
Scott Mattson, Alternate
Chicago Medical School
John D. Rogers, Delegate
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Loyola University
Kevin Tarrant, Delegate
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Rush Medical College
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Andrew Boshardy, Alternate
SIU School of Medicine
Kathy Hild, Delegate
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University of Chicago
JoAnne Micale, Delegate
Jong Kook Kim, Alternate
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John Elsen, Delegate
David G. Meyers, Alternate
University of Illinois-Rockford
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Vacancy, Alternate
University of Illinois-Peoria
Jack Ayres, Delegate
Allison Jones, Alternate
University of Illinois-Urbana
Michael Cantor, Delegate
Mark Byrne, Alternate

Council Representatives

Dipali Apte, Education & Manpower
Stephen Callaghan, Mental Health & Addiction
William A. McDade, Governmental Affairs
Jong Kook Kim, Economics
James L. Rising, Medical Services
JoAnne Micale, Public Relations and Membership Services
Andrew Chenelle, Financial Aid to Medical Students
Michael Cantor, Medical-Legal

Responsibilities and Purposes

The purposes of the Medical Student Section shall be to encourage and support the active participation of medical students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Medical Student Section shall support the purposes of ISMS as stated in its Constitution. The Medical Student Section is composed of all student members of ISMS.

Illinois State Medical Society Political Action Committee (IMPAC)

The Illinois State Medical Society Political Action Committee will begin its 29th year as a leader in medical politics in 1989. IMPAC is a voluntary non-profit, unincorporated, permanent membership organization. IMPAC serves as the unified political action arm of Illinois physicians and their spouses. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his/her spouse can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U.S. Congress.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U.S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Twenty North Michigan Avenue, Suite 700, Chicago 60602.

ISMS Resident Physicians Section

Bruce Doblin, *Chairman*
Judith Peters, *Vice Chairman*
Charles Terzian, *Secretary/Editor*
Gail Herman, *Delegate*
Bill Todia, *Alternate Delegate*
Timothy Kuzel, *Immediate Past Chairman*

Council Representatives

Charles Terzian, Education & Manpower
Andrew M. Basile, Governmental Affairs
John E. McConnell, Medical-Legal
Debra Klamen, Physicians Assistance (Voting)
Eslyn T. Garb, Physicians Assistance (Non-Voting)
Amy B. Forman, Economics
Timothy Kuzel, Medical Services
Rashid Soofi, Public Relations & Membership Services
Robert Mitrione, Mental Health & Addiction

Responsibilities and Purposes

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physicians Section shall support the purposes of the ISMS, as stated in its Constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.

MEDICAL AND ALLIED HEALTH EDUCATION

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago College of Osteopathic Medicine
555 31st St., Downers Grove, 60515
Loyola University, Stritch School of Medicine
2160 S. First Ave., Maywood, 60153
Northwestern University Medical School
303 E. Chicago Ave., Chicago, 60611
Rush Medical College
1653 W. Congress Pkwy., Chicago, 60612
Southern Illinois University School of Medicine
801 N. Rutledge, P.O. Box 19230, Springfield, 62794
University of Chicago-Pritzker School of Medicine
950 E. 59th Street, Chicago, 60637
University of the Health Sciences/The Chicago Medical School
3333 Green Bay Road, North Chicago, 60064
University of Illinois College of Medicine*
Chicago Campus
1853 W. Polk Street, Chicago, 60612
*Note: This is the main campus of the college. The college also has campuses in Peoria, Rockford and Urbana.

ALLIED HEALTH EDUCATION PROGRAMS

Accredited by the American Medical Association Committee on Allied Health Education and Accreditation

Cytotechnologist

CHICAGO—Michael Reese Hospital & Medical Center
University of Chicago Lying-in-Hospital

Diagnostic Medical Sonographer

RIVER GROVE—Triton College

Electroneurodiagnostic Technologist

SPRINGFIELD—St. John's Hospital

Histologic Technician

CHICAGO—Holy Cross Hospital
University of Chicago Hospitals and Clinics

PEORIA—St. Francis Hospital and Medical Center

SPRINGFIELD—Memorial Medical Center
St. John's Hospital

Medical Assistants

BELLEVILLE—Belleville Area College

CARTHAGE—Robert Morris College

PALATINE—William Rainey Harper College

PEORIA—Midstate College

RIVER GROVE—Triton College

Medical Illustrator

CHICAGO—University of Illinois at Chicago

Medical Laboratory Technician

BELLEVILLE—Belleville Area College

CHICAGO—Malcom X College

DES PLAINES—Oakton Community College

DIXON—Sauk Valley College

EAST PEORIA—Illinois Central College

GODFREY—Lewis & Clark Community College

GRAYSLAKE—College of Lake County

KANKAKEE—Kankakee Community College

PALOS HILLS—Moraine Valley Community College

RIVER GROVE—Triton College

QUINCY—Triton College

Medical Record Administrators

CHICAGO—Chicago State University
University of Illinois at Chicago

NORMAL—Illinois State University

Medical Record Technician

BELLEVILLE—Belleville Area College

CHICAGO—Truman College

DES PLAINES—Oakton Community College

GLEN ELLYN—College of DuPage

GRAYSLAKE—College of Lake County

PALOS HILLS—Moraine Valley Community College

Medical Technologist

BELLEVILLE—St. Elizabeth Hospital

CHAMPAIGN—Burnham City Hospital

CHICAGO—Louis A. Weiss Memorial Hospital
Rush-Presbyterian-St. Luke's Medical Center
St. Joseph Hospital
St. Mary of Nazareth Hospital Center
University of Illinois at Chicago Hospital

DANVILLE—Lakeview Medical Center

DECATUR—Decatur Memorial Hospital
St. Mary's Hospital

EVANSTON—Evanston Hospital
National College of Education

FREEPORT—Freeport Memorial Hospital

HINES—Edward Hines Jr. V.A. Hospital

HINSDALE—Hinsdale Hospital

JOLIET—St. Joseph Medical Center

MAYWOOD—Foster G. McGaw Hosp./Loyola University

NORTH CHICAGO—University of Health Sciences/Chicago Medical School

OAK LAWN—Christ Hospital

PARK RIDGE—Lutheran General Hospital

PEORIA—Methodist Medical Center of Illinois
St. Francis Hospital and Medical Center

ROCK ISLAND—Augustana College/ Quad City Hospital

ROCKFORD—Rockford Memorial Hospital
St. Anthony Hospital and Medical Center
SwedishAmerican Hospital

SPRINGFIELD—St. John's Hospital
Sangamon State University

UNIVERSITY PARK—Governors State University

Nuclear Medicine Technologist

GLEN ELLYN—College of DuPage

HINES—Edward Hines Jr. VA Hospital

PEORIA—St. Francis Hospital-Medical Center

RIVER GROVE—Triton College

Ophthalmic Medical Assistant

RIVER GROVE—Triton College

Occupational Therapist

CHICAGO—Chicago State University
University of Illinois at Chicago Hospital
Rush-Presbyterian-St. Luke's Medical Center

Perfusionist

MAYWOOD—Foster G. McGaw Hospital of Loyola University

Radiation Therapy Technologist

CHICAGO—Chicago State University
Michael Reese Hospital and Medical Center

ELGIN—St. Joseph Hospital

EVANSTON—National College of Education

HINES—Edward Hines Jr. VA Hospital

ROCKFORD—SwedishAmerican Hospital

Radiographer

ARLINGTON HTS.—Northwest Community Hospital

BELLEVILLE—Belleville Area College

CARBONDALE—Southern Illinois University

CENTRALIA—Kaskaskia Junior College

CHAMPAIGN—Parkland College

CHICAGO—Cook County Hospital
Malcolm X College
South Chicago Community Hospital
Wilbur Wright College

DANVILLE—Lake View Medical Center

DECATUR—Decatur Memorial Hospital

DES PLAINES—Oakton Community College

DIXON—Sauk Valley College

EAST PEORIA—Illinois Central College

ELGIN—St. Joseph Hospital

EVANSTON—St. Francis Hospital

GALESBURG—Carl Sandburg College

GLEN ELLYN—College of DuPage

GRAYSLAKE—College of Lake County

HINSDALE—Hinsdale Hospital

KANKAKEE—Kankakee Community College

MACOMB—McDonough District Hospital

MALTA—Kishwaukee College

MOLINE—Moline Public Hospital

NORMAL—Bloomington-Normal School of Radiology

OLNEY—Richland Memorial Hospital

PALOS HILLS—Moraine Valley Community College

PEORIA—St. Francis Med. Center

QUINCY—Blessing Hospital
St. Mary's Hospital

RIVER GROVE—Triton College

ROCK ISLAND—Franciscan Medical Center

ROCKFORD—Rockford Memorial Hospital
SwedishAmerican Hospital

SOUTH HOLLAND—South Suburban College of Cook County

SPRINGFIELD—Lincoln Land Community College
Memorial Medical Center

Respiratory Therapist

CARBONDALE—Southern Illinois University

CHAMPAIGN—Parkland College

CHICAGO—Malcolm X College

EAST PEORIA—Illinois Central College

EVANSTON—National College of Education

MOLINE—Black Hawk College

PALOS HILLS—Moraine Valley Community College

RIVER GROVE—Triton College

ROCKFORD—Rock Valley College

SPRINGFIELD—Lincoln Land Community College

Respiratory Therapy Technician

BELLEVILLE—Belleville Area College

CHICAGO—South Chicago Community Hospital

EAST PEORIA—Illinois Central College

GLEN ELLYN—College of DuPage

KANKAKEE—Kankakee Community College

MOLINE—Black Hawk College

ROCKFORD—Rock Valley College

SPRINGFIELD—St. John's Hospital

Specialist in Blood Bank Technology

CHICAGO—Life Source
Michael Reese Hospital and Medical Center
University of Illinois at Chicago

Surgical Technologist

CHAMPAIGN—Parkland College

EAST PEORIA—Illinois Central College

MOLINE—Moline Public Hospital

RIVER GROVE—Triton College

ROCKFORD—SwedishAmerican Hospital

WINFIELD—Central DuPage Hospital

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

Election of senators and representatives is determined in the apportioned districts throughout the state. One senator is elected from each of the 59 districts. Each Senate district contains two House districts. Members of the House of Representatives are elected from these 118 single member House districts.

The General Assembly convenes each year on the second Wednesday of January. The General Assembly is a continuous body during the two year term for which members of the House of Representatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. The committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Branch shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They are elected every four years.

STATE OFFICERS 1987

Governor, James R. Thompson, Rep., Chicago
Lieutenant Governor, George H. Ryan, Rep., Kankakee
Secretary of State, Jim Edgar, Rep., Charleston
Comptroller, Roland W. Burris, Dem., Chicago
Treasurer, Jerome Cosentino, Dem., Palos Park
Attorney General, Neil F. Hartigan, Dem., Chicago

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading, when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading, after which it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (60 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the governor for his consideration.

If the governor thinks the bill should become a law, he will sign it. If the governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each house can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The governor may also return a bill to the legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available at no cost to ISMS members. Requests should be directed to: Illinois State Medical Society, Regional Office, 701 S. Second St., Springfield 62704.

Department of Alcoholism and Substance Abuse

State of Illinois Center, 100 West Randolph Street, Suite 5-600, Chicago, 60601
222 South College, Springfield 62701
William T. Atkins, Director

The Illinois Department of Alcoholism and Substance Abuse is the state agency responsible for the public administration and funding of alcoholism and other drug abuse education, treatment, rehabilitation and prevention programs. The Department is responsible for administration of the Illinois triplicate prescription program for designated product controlled substances, scheduling of controlled substances, licensure for drug abuse programs and controlled substances research, training, and administration of initiatives for special populations and a wide variety of demonstration projects. The Department maintains administrative offices in Springfield and Chicago, and regional offices in Springfield, Chicago, Rockford and Mt. Vernon.

Administrative Staff

Mark T. Bishop, Deputy Director, Bureau of Regulatory & Management Services
Robert Stachura, Deputy Director, Bureau of Program Services.
Linda Hargnett, Deputy Director, Bureau of Planning Research and Development
Ronald Nelson, Chief Counsel
Tom Green, Chief, Office of Communications
Orisha Kulick, Executive Assistant to the Director
Felix Matlock, Administrator, Div. of Management & Budget
Mark T. Bishop, Acting Administrator, Division of Information Services
David Di, Administrator, Division of Field Services
Alvera Stern, Ph.D., Administrator, Division of Prevention & Education
Lillian Pickup, Administrator, Division of Planning
David Bingaman, Administrator, Division of Regulatory & Support Services
James Bixler, Administrator, Division of Program Development

STATUTORY BODIES

Illinois Interagency Alcoholism and Substance Abuse Board

Lt. Gov. George H. Ryan, *Chairman*
Janet Otwell, Director, Illinois Department on Aging
Ted Sanders, Superintendent, Illinois State Board of Education
Michael P. Lane, Director, Illinois Department of Corrections
Jeremy Margoles, Director, Illinois Department of State Police
Ann Kiley, Director, Illinois Department of Mental Health and Developmental Disabilities
Bernard Turnock, M.D., Director, Illinois Department of Public Health
Philip Bradley, Director, Illinois Department of Rehabilitation Services
Hon. Jim Edgar, Illinois Secretary of State
Gregory Baise, Secretary, Illinois Department of Transportation
Susan S. Suter, Director, Illinois Department of Public Aid
Gordon Johnson, Director, Illinois Department of Children and Family Services
Stephen Selcke, Director, Illinois Department of Professional Regulation
William T. Atkins, Director, Illinois Department of Alcoholism & Substance Abuse

Illinois Advisory Council on Alcoholism and Substance Abuse

Honorable Michael B. Getty, *Chairman*
Circuit Court of Cook County
Judy H. Fried, *Vice Chairperson*
Northern Illinois Council on Alcoholism
Russell J. Hagen, Vice Chairman
McLean County Alcohol and Drug Assistance Unit
Jeffrey Davison
Macon County State's Attorney
Donald Paull, Ph.D.
Mental Health Law Division
Cook County Public Defender
Robert Holder
Representative of Building Trades
Sam Gaines, M.D.
Hon. John Matijevich
Illinois State Representative
Hon. Thomas Dunn
Illinois State Senate
Hon. Kathleen L. Wojcik
Illinois State Representative
Hon. Frank Watson
Illinois State Senate
John A. Smith, Designee
Illinois Hospital Association
Violet Eggert, M.D., Designee
Illinois State Medical Society
Michael Stroden, Designee
Assoc. of Labor-Management Administrators & Consultants on Alcoholism
Antonio Garcia
Hispano Alcoholism Services
Rev. Donald M. Hallberg
Lutheran Social Services
Hon. Warren D. Wolfson
Circuit Court of Cook County
Sheriff Richard Doria
DuPage County Sheriff's Office
Sister Patricia Kilbane
Central States Institute of Addiction
Hon. Terry Steczo
Illinois State Representative
Hon. Dawn Clark Netsch
Illinois State Senate
Hon. Loleta Didrickson
Illinois State Representative
Hon. Forest D. Etheredge
Illinois State Senate
Marian Fiske, Designee
Illinois Nurses Association
Knute Connell
Illinois Pharmacists Association
Eldoris Mason
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Prairie Center
Peter Bokos, Ph.D.
Interventions, Inc.
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TASC, Inc.
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Norman Garfinkel
Pharmacy Consultant
Paul Teodo
Alcoholism Treatment Center, Central DuPage Hospital

Department of Children and Family Services

100 W. Randolph, Sixth Floor, Chicago, 60601
406 East Monroe, Springfield, 62701
Gordon Johnson, Director

The Illinois Department of Children and Family Services is the state agency responsible for providing child welfare and child protection services to children and their families. The current caseload is 46,720 children and families. Services provided by the Department, either directly or through purchase from private agencies, include counseling; the care of children in foster homes,

group homes, and institutions; adoption; day care; help to unwed parents, and the licensing and monitoring of some 16,000 child care facilities. The Department also contracts with individuals as advocates and homemakers to work with children and parents on a one-to-one basis.

The Department's Division of Child Welfare and Protective Services is responsible for the delivery of services to abused, neglected, and dependent children and their families. Child welfare staff administer the agency's various service programs for children and families, and protective services staff investigate reports of suspected child abuse and neglect. In fiscal year 1988, almost 94,000 children were reported as suspected victims of abuse and neglect.

The Division of Youth and Community Services specializes in services for adolescents. It is responsible for a grant-in-aid program of community-based services to troubled youth, juvenile justice and delinquency prevention programs, a multi-agency program for emotionally disturbed youngsters, and a variety of youth employment programs.

Director's Office

Michael Horstman, Executive Deputy Director
Robert T. Blackwell, Special Assistant to the Director
Janis Forte, Special Assistant to the Director
Thomas E. Villiger, Deputy Director, Division of Child Welfare and Protective Services
William Hall, Deputy Director, Division of Policy and Plans
John Petrilli, Deputy Director, Division of Youth and Community Services
David Richards, Deputy Director, Division of Management and Budget
Jo Warfield, Chief, Office of Communication/Community Relations
Mauriece Graham, Chief, Office of Audits
Robert Moore, Chief, Office of Investigations
William Curtis, Chief Counsel, Office of Legal Services
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Linda Avery, Chief, Office of Program Review
Linda Avery, Chief, Office of Inter-Agency Coordination

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State Advisory Committee on Day Care, Miriam Klimstra, Chairperson
Illinois Juvenile Justice Commission, Dallas C. Ingemunson, Chairperson
Statewide Foster Care Advisory Committee, Donna Manson, Chairperson
Child Welfare Advisory Council

In addition to the above, each of the eight regions has its own advisory committee and various youth planning committees.

Department of Corrections

100 West Randolph, 4th Floor, Chicago 60601
1301 Concordia Ct., P.O. Box 19277, Springfield 62794-9277
Michael P. Lane, Director

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James R. Irving, Deputy Director-Juvenile Division
Anthony Scillia, Deputy Director-Community Services Division
Karl Becker, Deputy Director-Bureau of Administration and Planning
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Melissa A. Stutler, Chief of Intergovernmental Relations
Ronald Shansky, M.D., Medical Director

Programs: 1) To develop and maintain reception and evaluation units for the purpose of analyzing the security, physical and mental needs of juvenile and adult offenders committed to it and to assign such persons to institutions and programs under its control or transfer them to other appropriate agencies; 2) to develop and maintain programs of control, adjustment and employment of committed persons within its institutions; 3) to establish a system of release, supervision and guidance of committed persons in the community; 4) to maintain records of persons committed to it and to establish programs of research, statistics and planning; 5) to investigate the grievances of any person committed to the agency and to inquire into any alleged misconduct by employees; and 6) to cooperate with other departments and agencies and with local communities for the development of standards and programs for better correctional services within the state.

Department of Mental Health and Developmental Disabilities

State of Illinois Center, 100 West Randolph, Suite 6-400, Chicago 60601
401 S. Spring St., Springfield 62706
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John Fangman, Deputy Director for Central Operations
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Ugo Formigoni, M.D., Associate Director for Mental Illness
William Murphy, Associate Director for

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Department of Public Aid

624 S. Michigan Ave., Chicago 60605
100 South Grand Ave. East, Springfield 62762
Susan S. Suter, Director

The Illinois Department of Public Aid assists over one million Illinois residents experiencing financial or medical hardships. The Department administers the following programs: Aid to Families with Dependent Children, Medical Assistance, and Aid to the Aged, Blind, or Disabled. The Department also allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp Program. The Child Support Enforcement Program is a joint effort of the Department, the Attorney General, and local state's attorneys to obtain court-ordered child support from parents. Support enforcement services are provided to any family that needs help collecting child support. Project Chance, a welfare-to-work program, offers job placement services, training, education and support services to guide welfare recipients away from dependency and into the work place. The Department's Office for Hospital Services in the Medical Programs Division administers the Illinois Competitive Access and Reimbursement Equity Program (ICARE), which assures access to quality hospital care for recipients and promotes competition among hospitals for the purchase of their services. Among other initiatives within the Medical Programs Division are nursing home reform and prepaid health programs.

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E. P. Johnson, Casey (IDPA Consultant)

Department of Public Health

100 West Randolph, Suite 6-600, Chicago 60601
535 West Jefferson St., Springfield 62761
Bernard J. Turnock, M.D., Director

The Illinois Department of Public Health promotes the good health of the public through the administration of more than 100 programs and services aimed at preventing illness, eliminating health hazards, regulating health-care facilities, identifying and controlling outbreaks of disease and reducing health-risk factors.

The scope and variety of programs admin-

istered by the Department encompass all aspects of preventing disease and disability, thus improving the quality of life for Illinois residents.

The reduction of infant mortality; nutrition services; pre- and postnatal care; dental health; emergency medical services; childhood immunizations; maintenance of breath-analysis equipment; control of sexually transmitted diseases; assuring the purity of food, milk and drugs; regulation of health-care facilities; elimination of health hazards from the environment; licensure and regulation of swimming pools and other recreational areas; support to local health departments; consumer product safety; and the registration of births, deaths and other vital statistics are among the myriad of programs and services administered by the State Health Department.

Administrative Staff

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Recreated, Ch. 127, par. 6.06a
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AIDS Interdisciplinary Advisory Council (AIAC)

*Membership of new AIDS Advisory Council currently pending appointment.

POISON CONTROL CENTERS IN ILLINOIS

For information contact:
Division of Emergency Medical Services & Highway Safety
Illinois Department of Public Health
525 W. Jefferson
Springfield, 62761
Phone: (217) 785-2080

APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS
Illinois Department of Public Health
Division of Disease Control

For information contact:
Mary Mahoney—Coordinator, Direct Services Programs
Illinois Department of Public Health
Room 150, 535 West Jefferson Street, Springfield, 62761
Phone (217) 782-3303

Department of Professional Regulation

320 W. Washington Street, Springfield 62786
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Deputy Director/Licensing and Testing
Anthony Erbacci, Chief of Medical Prosecutions
Russ Sonneveld, Chief of Medical Investigations

The Department is primarily concerned with the registration, licensing and enforcement of 30 different professions, and occupations, including the Medical Practice Act.

The Medical Licensing Board, appointed by the director of the Department, operates within the framework of the Act and is charged with the responsibility of supervising examinations for licensure and making recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board, appointed by the Governor, reviews alleged violations of the Medical Practice Act, hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

Illinois Licensing Board

Dean R. Bordeaux, M.D., Peoria
Jere E. Freidheim, M.D., Burr Ridge
Arvind Goyal, M.D., Itasca
Lawrence L. Hirsch, M.D., Northbrook
John Holland, M.D., Springfield
Lawrence S. Levin, D.C., Chicago
Larry S. Patton, D.O., Morton

Illinois State Medical Disciplinary Board

Otto Brosius, M.D., Decatur
Irene Caruso, M.D., Galesburg
Susan Enlow, Springfield
Robert L. Hambrick, D.O., Burr Ridge
Joseph Perez, M.D., Rockford
Biswamay Ray, M.D., Oak Brook
Warren Staley, M.D., Chicago
Virgil C. Wikoff, Champaign
Karl H. Zimmer, D.C., Evanston

MEDICAL PRACTICE ACT

The Illinois Medical Practice Act underwent sunset review in 1987, and the new Act is a document of importance to every Illinois physician. Although its length prohibits publication of the complete text, members are encouraged to obtain a copy of the Act from the Department of Professional Regulation, 320 W. Washington Street, Springfield 62786. Readers are also referred to the September, 1987, *IMJ* for highlights of the new Act and a review of attendant issues.

Department of Rehabilitation Services

623 East Adams Street, P.O. Box 19429, Springfield, 62794-9429
Philip C. Bradley, Director

The Department of Rehabilitation Services (DORS) is the state's leading agency helping children and adults with disabilities to reach their full potential and their goals for a productive independent life. Funded by state and federal funds, DORS provides a variety of rehabilitation services to eligible persons, including children who cannot be adequately served by their local public schools; adults of or near working age who have diagnosable physical and/or mental disabilities which interfere with their ability to get or keep jobs; and adults with severe disabilities under age 60 who are at risk of institutionalization but who could remain at home if certain, specific services were provided.

DORS assists clients in selecting the needed services; serves as a link to service groups, rehabilitation facilities and other governmental agencies; and makes medical eligibility determinations for persons applying for benefits under the Social Security Disability Insurance and Supplemental Security Income programs.

DORS offers its services through a number of program components, including the Vocational Rehabilitation Program, the Home Services Program, the Illinois Visually Handicapped Institute, Community/Field Services for the Visually Handicapped, the Illinois School for the Deaf, the Illinois Children's School and Rehabilitation Center, the Illinois School for the Visually Impaired, secondary school work experiences and the Vending Stand Program.

Illinois Health Care Cost Containment Council

516 E. Monroe St., Suite 200, Springfield 62701
Marilyn Plomann, Executive Director

In August, 1984, Illinois Governor James R. Thompson signed into law Senate Bill 495, which created a new body reporting directly to the Illinois General Assembly. That body, the Illinois Health Care Cost Containment Council, was appointed to fulfill the legislative mandate to monitor the cost of health care in Illinois. The responsibilities of the Council include studying, recommending, and implementing measures to control health care costs as well as encouraging new and innovative methods of financing health care. The data system established by the Council presently collects hospital inpatient discharge data, Medicare cost reports, hospital annual financial data and prices for selected inpatient services. The Council issues quarterly reports and consumer materials regarding hospital charge and utilization trends. The Council members include: three health care providers, three consumers, two insurers, and three representatives of the business community.

Health Care Provider Representatives:
Charles B. Van Vorst, Champaign
Robert K. Burger, Chicago (ISMS)
Ruth Rothstein, Chicago
Business Community Representatives:
Johanna M. Lund, Rockford, *Chairman*
Raymond B. Werntz, Chicago
Kenneth J. Morrissey, Naperville
Consumer Representatives:
William N. Frayser, Broadview
Larry Lawler, Decatur
Edward H. Mazur, Ph.D., Chicago
Insurance Industry Representatives:
Don Ames, Chicago
Charles R. Goulet, Geneva

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the reference section. Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

Name: _____ **City:** _____ **Zip:** _____

Address: _____

Telephone: () _____

County Medical Society: _____

Medical specialty and type of practice: _____

Committee in which interested: _____

Expertise for this committee: _____

Send to: Chairman, Board of Trustees, Illinois State Medical Society
Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602

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PEDIATRICIAN WANTED to establish practice in NW Illinois city of 17,000, service area 60,000+. Space available in fully-equipped office 1 block from hospital with new peds. unit and level II nursery. 100% of collections, no buy-in. Office rent negotiable. 1-2 hours from Chicago, other large cities. For more information or to schedule visit, write S. Baumwell, M.D., 202 W. Miller Road, Sterling, IL 61081 or call collect (815) 626-9660.

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WANTED—BOARD ELIGIBLE/BOARD certified emergency medicine physician to join an emergency department staff which is part of a 200 physician multi-specialty clinic in Champaign-Urbana, Illinois; 35,000 annual visits. Liberal fringe benefits and salary lead to equal ownership. Send CV with inquiries to J. Yambert, M.D., Division of Emergency Medicine, Carle Foundation Hospital, 611 West Park, Urbana, IL 61801; (217) 337-3313.

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GENERAL PRACTITIONER—W. suburbs part-time, occupational medicine, hospital clinic, 8:00 AM-5:00 PM, 1-3 shifts-week. Contact: K. Smith, D.O. (312)790-6387.

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CHICAGO PRACTICE SEEKS FP, IM, PEDS, OB/GYN. Second language desirable. Send CV: Med West Consultants, Inc., P.O. Box 339, Wilmette, IL 60091.

ILLINOIS LICENSED general practitioner needed, full time opportunity forty hrs. week for clinic located on west side of Chicago. Salary, bonus. Call (815) 672-7181.

CHIEF PATHOLOGIST—Staff pathologist—The pathology department, St. Joseph Mercy Hospital, a 312 bed rural referral center with a 200,000 service area population, is seeking a chief pathologist and staff pathologist. The hospital performs over 6,500 surgical procedures annually with an extensive medical staff of 160 physicians representing many specialties. Must be AP/CP certified/eligible. Area offers superb quality of life with the availability of recreational and cultural activities. This is an excellent opportunity with a competitive salary. Interested applicants send C.V. to: George Joyce, MD, Chief—Department of Pathology, St. Joseph Mercy Hospital, 84 Beaumont Drive, Mason City, IA 50401.

PEDIATRICS—Marshfield Clinic, a 270-physician, multi-specialty private group practice, is seeking a board certified or eligible general pediatrician to join its expanding regional center in Chippewa Falls. Chippewa Falls is a community of 15,000 people located in beautiful west central Wisconsin with a wide range of recreational, educational, and cultural opportunities easily accessible. The clinic is adjacent to a 110-bed JCAH accredited hospital. Competitive salary and fringe benefit package. Send curriculum vitae and references to: Mr. David Draves, Director, Regional Development, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449. Or you may call collect at (715) 387-5376.

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ILLINOIS, QUAD-CITIES AREA: Seeking emergency medicine physicians with residency training and/or prior ED experience for both full-time and locum tenens opportunities, in very attractive, high volume facility. Excellent nursing staff. Above average compensation, malpractice insurance and flexible scheduling. Benefit package available to full-time physicians. For more information contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

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FAMILY PRACTITIONER needed for established clinic, located in the Black Hills. New hospital and clinic. Contact Lanny Reimer, M.D. (307) 746-3582 or Evonne Ulmer, C.E.O. at Weston County Hospital, 1124 Washington Blvd., Newcastle, WY 82701; (307) 746-4491. Opportunities also available for general surgeon—internal medicine.

FAMILY PRACTICE—FOR SALE. Small town—NW Indiana. High income. Hospital in town. OB/ER/optional. Hospital may assist financially. Chicago 90 minutes. South Bend 60 minutes. Reply: PO Box 93, Valparaiso, IN 46384.

ANESTHESIOLOGIST: PART TIME, for backup in established freestanding ambulatory surgery center in SW of Chicago. Send CV & references to Box 2118 c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SITUATIONS WANTED

BOARD-CERTIFIED OB/GYN seeking part-time positions. Please reply to Box 2047, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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FAMILY PRACTICE grossing 400,000 yearly—university town of 20,000—good hospital—ideal for one or two GPs—terms negotible—write or call: Lewis E. Adkins, M.D., 730 Sixth Street, Charleston, Illinois 61920. Phone (217) 345-5709.

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MISCELLANEOUS

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Exchange Insights

October, 1988

ON MALPRACTICE PREVENTION

The Board of Governors of the Illinois State Medical Inter-Insurance Exchange presents "Exchange Insights on Malpractice Prevention" as a service to Illinois State Medical Society members and Exchange policyholders. This monthly feature is designed to educate physicians on those areas in their practice which have the potential for causing claims, and to offer possible ways to minimize risks. **Exchange Insights** *may be removed and kept with your other important Exchange professional liability information.*

When Something Goes Wrong

by Edward T. Butt, Jr., J.D.

It is nearly impossible to determine before treatment which types of patients are more likely to sue if something goes wrong. There is, however, a common characteristic often found in medical malpractice plaintiffs: many have been, or at least claim to have been, offended by the physician's attitude following the complication or untoward result.

Because medicine is still as much art as science, and because Marcus Welby is the only physician not limited by human frailties, there will be times when complications or undesired results occur. How do you tell the patient and family? My experience with the situation is atypical. Except for one instance discussed below, my experiences are with patients who have already sued. Because of this, I can offer some advice on what not to say and do.

The Best Policy

Whatever you do, do not lie or attempt to cover up the bad results. First, when the patient finds out the truth, he will jump to the conclusion that malpractice was the cause of the problem and will go directly to a lawyer. In fact, in such cases, patients have gone from lawyer to lawyer until one finally agreed to take the case. If patients had been told the truth at first, they might have given up after being turned down by a lawyer the first time.

Second, and more important legally, fraudulent concealment of the injury or of the negligent act keeps the statute of limitations from running out. The patient can bring suit within five years of his discovery of the malpractice, no matter when that discovery takes place. The medical malpractice statute ot limitations (two years from date of discovery and four years from date of incident) specifically excepts cases of fraudulent concealment.

Finally, if you are later forced to admit the truth, the jury might view your coverup as an admission of guilt. Whatever you say, tell the truth.

Taking Time

Another common complaint voiced by patients is that the physician had avoided talking about the problem with them, either by not returning their telephone calls or by evading their questions about the complication and its prognosis. It is human nature to prefer to talk about successes. It is more important, however, to face patients when there has not been complete success. Being unwilling to talk about complications, while not as bad, tends to have the same effect on patients as those discussed above regarding misstatements.

Moreover, the suspicions arise sooner. Several plaintiffs have testified that they first become suspicious that the complication might have been caused by malpractice when the physician refused to openly discuss the situation with them. In addition, under some circumstances, courts have held that a failure to tell the patient about the unexpected result also can toll the running of the statute of limitations. Although it is not always easy, make sure you sit down with the patient and his family, give them plenty of time and answer any questions they might have.

Only a lawyer will, after having told you that you must talk to the patient, go on to say that you must be careful about what you say. You can express concern and compassion, but do not say, "It was my fault," "I made a mistake," or "I am sorry." These phrases can be misunderstood as admissions of fault and can be used against you. You can talk about the problem, how it might have been caused, what precautions you took to avoid the problem, and what might be done to correct it, without admitting fault. One can only hope that you had warned the patient of the possibility of the particular complication when obtaining informed consent for the procedure; the discussion of the complication is a lot easier then.

Laying blame on someone else will not be of any particular help to you either. If a lawsuit is brought, the plaintiff's attorney will also name you as a defendant, and

during the suit the person you accused will be pointing his finger at you. You should always discuss the involvement of others in the same terms suggested above for use in discussing your own role. When asked directly whether someone else made a mistake, if you cannot categorically support his actions, you can usually say that he is a specialist and an expert in his field, that he is well qualified and that you have to defer to his judgment. You cannot misstate the facts, but going out of your way to blame someone else will not help you either.

Counting on Rapport

The relationship between the patient and the physician, and the physician's and patient's personalities are key factors in determining how best to discuss complications and unfortunate results. As I mentioned above, I only have one experience with how to do it properly.

During the birth of my first child, my wife went into shock after an extremely long and difficult induced labor. Fortunately, no long term problems resulted, but I always have been impressed by how the obstetrician dealt with me. (Admittedly, my profession and my presence during the delivery might have had some effect, but knowing this particular physician, I doubt it.)

As soon as mother and daughter left the delivery room, the physician and I went to the doctor's lounge in the obstetrical wing. He explained that the shock might have been caused by his injecting lidocaine into a blood vessel despite precautions he takes to avoid doing so, and it could have been that the delivery was just too difficult. He asked rhetorically whether, in hindsight, he might have opted for a C-section. "Maybe," he explained, "but in view of the x-rays taken before the delivery, there did not appear to be any problem."

Even though I am a trained skeptic, I felt very comfortable with his explanation, and if permanent problems had arisen, I would not have been going out of my way to look for a lawsuit. This was only one approach, but based on the personalities of the physician and the patient's husband, it was one which was very effective.

As long as you approach situations openly and honestly, but without being overly self-critical, you too can communicate with the patient to minimize your chance of being unnecessarily sued.

Exchange Insights is not intended to provide legal advice, and no attempt is made to define conduct which would have been appropriate in particular cases to meet acceptable standards of care.

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Official Journal of the Illinois State Medical Society

Volume 174, Number 5, November 1988

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REPORT FOR *Illinois Physicians*

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If you are not currently submitting claims electronically, but are interested in doing so, you can contact the following **SOFTWARE VENDORS** for information:

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Also, many hospitals in Illinois are submitting claims electronically for physicians. You can contact your hospital's business office for information about submitting your Blue Shield and Medicare "B" claims.

If you already have the capability to submit claims electronically and are interested in billing us directly, or you would like further information on hospitals, or software vendors listed, please call us at (312) 938-7697.

BEAUTIFUL BABIES RIGHT FROM THE START

The **"Beautiful Babies Right from the Start"** campaign begins in the Chicago area this fall. As part of its continuing effort to promote the highest quality of health care for the citizens of Illinois, Blue Cross and Blue Shield of Illinois is pleased to offer its support and endorsement to the **"Beautiful Babies"** campaign.

Insufficient prenatal and pediatric care is the single most factor responsible for the country's alarmingly high infant mortality rate. In its endorsement of **"Beautiful Babies Right from the Start"**, the Illinois State Medical Society astutely observes that "the lack of proper prenatal care ... crosses all demographic lines, pervading every age, socioeconomic and social grouping within our society."

A **"Beautiful Babies"** pilot program conducted in Washington, D.C. attained the participation of eighty percent of the area's expectant mothers. With your help, we are certain that the Chicago area campaign will achieve even greater success.

Shortly, you will be asked to confirm your participation in this innovative campaign. We are hopeful that you will share our enthusiasm and welcome the opportunity to contribute to the resolution of one of the country's most distressing healthcare problems.

MEDICARE NOTES

ADDITIONAL INFORMATION: THROMBOLYTIC THERAPY

In our April 1988 Major Mailing and the April 1988 Blue Sheet, you were notified of Medicare's coverage of thrombolytic therapy under the procedure codes listed below. This procedure was covered, effective with services performed on or after January 16, 1988, when streptokinase was utilized. Coverage has now been extended to include both Urokinase and TPA (Tissue Plasminogen Activator). To bill for physicians' services for this procedure, please use:

92975 Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiography.
92977 As above; by intravenous infusion.

ANESTHESIA REMINDER

Modifier AA — Anesthesia services personally furnished by anesthesiologist
Modifier AD – Supervision of more than 4 concurrent anesthesia services by anesthesiologist (Automatically denied by Medicare B)

These modifiers, among others, were listed in our April 1988 Major Mailing. They became effective April 1, 1988. We remind you of these 2 codes because they are being used interchangeably in error.

WARNING: PREPARE FOR DIAGNOSIS CODING REQUIREMENT!

The Medicare Catastrophic Coverage Act of 1988 (Section 202, paragraphs g and k4) requires that appropriate diagnostic coding must be included on each physician bill submitted for services furnished on and after April 1, 1989. It is not yet known whether "sympomatic" codes will be acceptable.

The diagnosis coding is targeted for future use as a utilization review tool, as part of the new catastrophic health insurance law. If the diagnosis code does not match up with the CPT-4/HCPCS procedure code being billed, the claim could require further review by the carrier to determine medical necessity. Practices not presently using superbills and physicians who bill non-assigned claims will feel the greatest impact.

Please focus on the fact that this is a "warning." The information given is all that is available. Some of you may need to make systems changes. We understand that some practices don't have ICD-9 coding manuals so you may choose to order one. Just as soon as more information becomes available from Health Care Financing Adm. on this subject, you will be notified.

CATARACT SURGERY—PREOPERATIVE EXAM (Effective for services performed on or after 9/14/88)

Cataract surgery with an intraocular lens (IOL) implant is a high-volume Medicare procedure. Along with the surgery, a substantial number of preoperative tests are available to the surgeon. In most cases, a comprehensive eye examination (ocular history and ocular examination) and a single scan to determine the appropriate pseudophakic power of the IOL are sufficient. In most cases involving a simple cataract, a diagnostic ultrasound A-scan is used. For patients with a dense cataract, an ultrasound B-scan may be used.

Accordingly, where the only diagnosis is "cataract(s)", Medicare will not routinely cover testing other than one comprehensive eye examination and an A-scan or, if medically justified, a B-scan. Claims for additional tests will be denied as not reasonable and necessary unless there is an additional diagnosis and the medical need for the additional tests is fully documented.

Because cataract surgery is an elective procedure, the patient may decide not to have the surgery until later, or to have the surgery performed by a physician other than the diagnosing physician. In these situations, it may be medically appropriate for the operating physician to conduct another examination. To the extent the additional tests are considered reasonable and necessary, they would be covered.

(This report is a service to the physicians of Illinois)
11/88

IMJ

Illinois Medical Journal
Illinois State Medical Society

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November 1988

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Healthy Risk-Taking: Guiding Young People to Sound Decisions



Late in the fourth quarter in last month's game against the San Francisco 49ers, Coach Mike Ditka decided to take a risk. The Chicago Bears had the ball on their own 45-yard line. It was fourth-and-inches with 2:51 left, and Ditka decided to go for it. The 49ers held and took possession, and Ditka's risk did not pay off. But, no matter. The Bears held the 49ers and got the ball back. One minute and 11 seconds later the Bears won 10-9.

Ditka's risk was a calculated one. He knew he had a classic fourth down situation which obviously meant a Kevin Butler punt, thus saving both field position and post-game criticism. But defensive back Mike Singletary was screaming in Ditka's ear that even if the 49er offense took over, the mightly Bear defense would keep them at bay. Not to worry, take the risk—it was worth it. And anyway, Ditka knew, it was just a game.

Risk-taking is quintessentially American. If we do not risk, we often do not achieve what we want or need or believe in. Yet, the inherent dangers of risks must be contained and minimized. As adults, we've hopefully learned to achieve the delicate balance between the calculated risk and the foolish gamble. Also, as adults, we retain the responsibility to pass this lesson on to our young people.

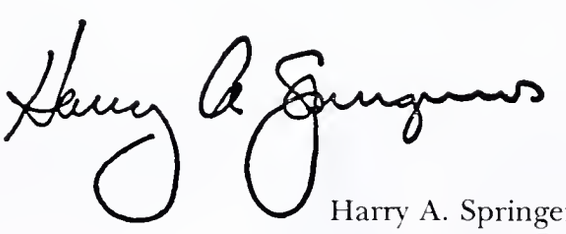
There is no question in my mind that the vast majority of America's youth are bright, motivated and "together" kids. Yet, the alarming increase in substance abuse-related violent deaths among America's adolescents is providing ample evidence that not all of our young people are learning how to distinguish between the risks that help them grow up and those that can seriously hurt them. Too many of our young people are out there taking the foolish gambles, often all by themselves, and we are paying the price.

Medical studies clearly demonstrate that "violence" is the number one killer of America's teens. Three out of four who die suffer a violent end. And more than half of those deaths are accidents—primarily auto accidents. Despite what we see in the media about the growth of gang violence, drug abuse and other teen hazards, auto accidents are the leading cause of death among 15- to 24-year-olds.

It's not that teenagers are totally unaware of the risks. Indeed, according to a survey conducted by the *Weekly Reader,* a children's magazine distributed in schools nationwide, 44 percent of fourth graders said their parents know a lot about drugs and drinking among kids. Yet, the older the kids get, the less the parents seem to know. Only about 20 percent of the kids in grades seven through 12 said their parents knew what was going on.

Those same kids said that "teaching their kids about drugs" was the most important thing their parents could do to help. Parents who take the time to help their kids understand the foolishness of the drug and alcohol risk have a better chance of reducing the attractiveness of experimenting than those who do not. It is especially important to emphasize the dangers of the so-called "gateway drugs" such as tobacco and alcohol. Moreover, such guidance needs to happen in an atmosphere of trust, understanding and love instead of recrimination and fear.

The approaching holidays will bring us a lot more football, along with the opportunities for our young people to participate in the risks of growing up. Some of those risks will be growth-enhancing and well worth taking. Others will manifest themselves in violent accidents resulting in serious injury or worse. As a physician and ISMS president, I will continue to speak out on the dangers of the wrong kind of risk. I hope that you, my colleagues, will join me. ◀



Harry A. Springer, M.D.
President

ABSTRACTS OF ACTIONS

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

September 10, 1988 — *ISMS Conference Complex*

HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

In 1986 the President signed the Health Care Quality Improvement Act into law (S 1744). This Act created a national data bank regarding adverse credentialing reports and established various requirements for peer review activities. The Act will be effective in October, 1989, at which time ISMS, state agencies and Illinois hospitals must be in compliance. In the alternative, Illinois could implement its own law.

The AMA had initially joined with the Federation of State Licensure Boards to enter a bid to be the contractor for the data bank. Funding problems have caused this to now be rebid. The AMA master file is crucial to the data base. An update on the status of the data bank is to be presented at the All Member Conference.

In order to develop responses and provide assistance to our members, county medical societies and hospital medical staffs, the Board authorized legal counsel to develop a series of four review papers regarding the federal Health Care Quality Improvement Act of 1986 (S 1744). The papers will cover: (1) A comprehensive analysis of the Act and its interrelationship with present Illinois law; (2) An analysis of options available; *i.e.* should Illinois opt out and enact a similar statute, possible changes in Illinois licensure acts, a review of peer review provisions in the ISMS bylaws, recommendations for hospital medical staff bylaws, a descriptive data bank reporting requirements; (3) Recommendations on options which should be pursued by ISMS; and (4) Guidelines for use by hospital medical staffs regarding peer review and credentialing decisions.

RELATIVE VALUE SCALE

The long awaited American Medical Association/Harvard Resource Based Relative Value Scale (RBRVS) study was to be delivered to the Health Care Financing Administration (HCFA) on July 15th and made public one month later. Because of last minute modifications the RBRVS now is not expected to be delivered to the HCFA until late September. The Board believed that an ISMS position should be developed on RBRVS, and that the Executive Committee consider a special meeting of the Board of Trustees or House of Delegates to address questions on RBRVS.

DUE PROCESS

The Society, with legal counsel review, has revised the ISMS document "Due Process Guidelines for Physicians." The booklet will be promoted to ISMS members and sent out upon request. Legal counsel noted upon review that the Guidelines recommends that bylaws include a provision for a physician to challenge, for cause, any member of an investigation team or hearing body. There is no basis for such a "right" in federal or Illinois law, though hearings are to be free of bias. Subsequently, legal counsel suggested that ISMS adopt a policy that a physician should be able to challenge anyone for cause.

In light of this recommendation, the Board adopted a resolution, to be submitted to the 1989 House of Delegates, calling for an ISMS policy stating that "A physician should have the right to challenge, for cause, anyone who serves as a member of an investigation team or hearing body looking at allegations or taking action against the physician."

OFF-SITE REVIEW

Representatives of ISMS and the Crescent Counties Foundation for Medical Care (CCFMC), the Illinois PRO, met and discussed the proposed PRO Scope of Work Document for 1988-1990. This document serves as the basis for the Health Care Financing Administration's (HCFA) evaluation of CCFMC's performance under its PRO review contract. While CCFMC has very limited discretion in deviating from the Scope of Work Document, the Society believes that there may be some areas of the review process that should be modified. In particular, the issue of use of specialty reviewers (*i.e.*, a reviewer of the same specialty as the physician under review) at an earlier stage in the review process to avoid unnecessary reconsideration hearings. CCFMC indicated that in order to accommodate the request for earlier specialty review in utilization review, specialty review may need to be conducted off-site. This would occur after an initial on-site review had occurred. CCFMC expressed its willingness to consider conducting off-site specialty review on a limited basis at the request of the targeted physician.

The Board agreed to encourage CCFMC to develop a review protocol to allow limited use of off-site review

(continued on page 311)



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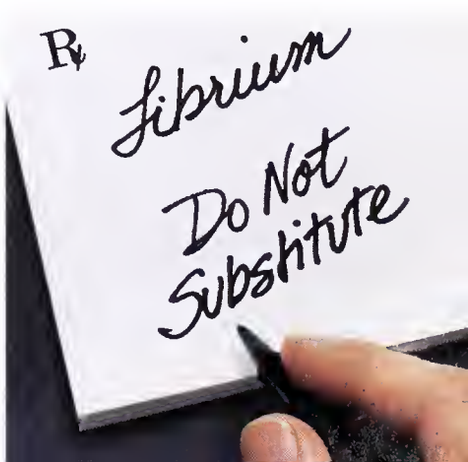
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OBITUARIES

***Adelman, Raphael M.,** Waukegan, died August 31, 1988, at the age of 73. Dr. Adelman was a 1945 graduate of the University of Health Sciences/Chicago Medical School.

****Bliss, Libuse K.,** Algonquin, died July 31, 1988, at the age of 82. Dr. Bliss was a 1930 graduate of Rush Medical College, Chicago.

***Blough, George J.,** Chicago, died August 15, 1988, at the age of 70. Dr. Blough was a 1943 graduate of Loyola University Stritch School of Medicine, Maywood.

Bouffard, Darryl A., Chicago, died May 25, 1988, at the age of 43. Dr. Bouffard was a 1970 graduate of the University of Illinois College of Medicine, Chicago.

Cryns, Werner, Milwaukee, Wisconsin (formerly of Chicago), died September 13, 1988, at the age of 68. Dr. Cryns was a 1948 graduate of Loyola University Stritch School of Medicine, Maywood.

****Gordon, H. Samson,** Chicago, died September 10, 1988 at the age of 81. Dr. Gordon was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

Handelman, E. V., Chicago, died September 23, 1988, at the age of 69. Dr. Handelman was a 1942 graduate of the University of Illinois College of Medicine, Chicago.

Hirsch, Edwin I., Chicago, died September 14, 1988, at the age of 73. Dr. Hirsch was a 1941 graduate of the University of Health Sciences/Chicago Medical School.

****Irace, Henry E.,** Palos Park, died August 15, 1988, at the age of 78. Dr. Irace was a 1935 graduate of Loyola University Stritch School of Medicine, Maywood.

****Kraft, Frank P.,** Oak Lawn, died September 21, 1988, at the age of 81. Dr. Kraft was a 1934 graduate of Northwestern University Medical School, Chicago.

***London, William N.,** Chicago, died August 14, 1988, at the age of 64. Dr. London was a 1955 graduate of Meharry Medical College School of Medicine, Nashville, Tennessee.

***Mauer, Edwin L.,** Libertyville, died August 19, 1988, at the age of 56. Dr. Mauer was a 1957 graduate of the University of Michigan Medical School, Ann Arbor, Michigan.

***McGann, Raymond J.,** Springfield, died July 28, 1988, at the age of 73. Dr. McGann was a 1940 graduate of Northwestern University Medical School, Chicago.

***Rachuy, Lyle A.,** Stockton, died August 16, 1988, at the age of 71. Dr. Rachuy was a 1950 graduate of Northwestern University Medical School, Chicago.

***Rowe, Harry R.,** Long Beach, California, died August 15, 1988, at the age of 77. Dr. Rowe was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

***Seitam, Arnold,** Elmhurst, died September 12, 1988, at the age of 69. Dr. Seitam was a 1948 graduate of Medizinische Fakultat der Georg-August-Universitat, Gottingen, Niedersachsen, Germany.

****Sondag, Roger F.,** Springfield, died August 21, 1988, at the age of 78. Dr. Sondag was a 1936 graduate of the University of Illinois College of Medicine, Chicago.

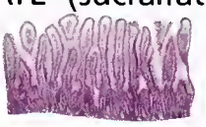
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BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE
There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other. Issued 1/87

Reference:
1 Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987, 9(4):395-399

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In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

CHICAGO SUBURBAN:

MacNeal Hospital, a major teaching affiliate of Rush-Presbyterian-St. Luke's Medical Center, seeks family practitioners and obstetricians. Opportunities include private practice, solo, partnership, practices for sale, salaried positions. Individualized comprehensive financial package. BE/BC family practice; OB/BC family practice; OB/GYN. Forward CV: Physician Affairs, 3249 S. Oak Park Avenue, Berwyn, IL 60402. (10)

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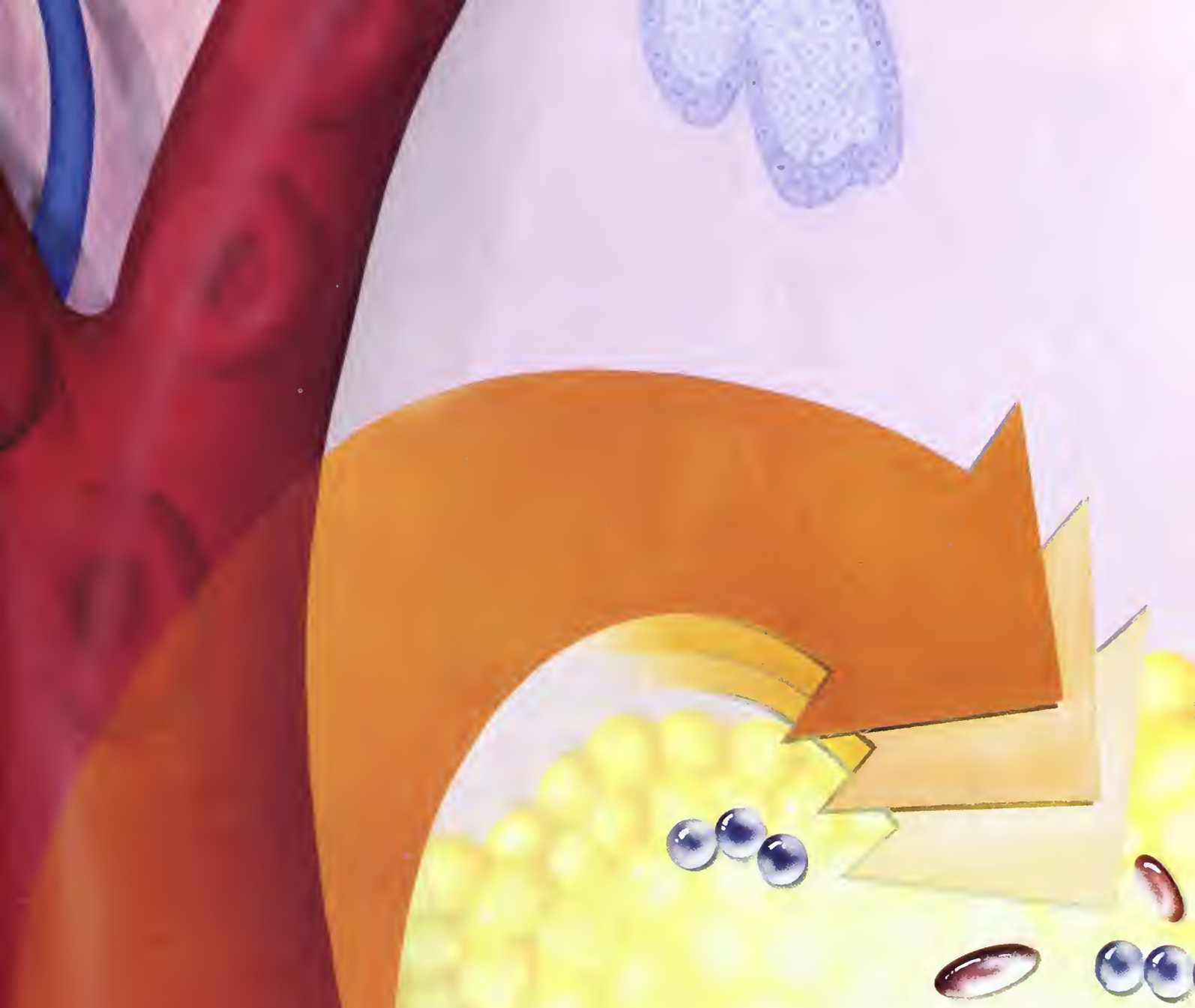
South Suburban Hospital has immediate opportunity for board certified, or board eligible family practitioner/internist. Physician will assume control of well established practice of retiring physician. Relocation allowance; loan guarantees: marketing support available. Will consider candidates currently finishing residency. For this and other practice opportunities, direct C.V. to Joe Dwyer, Vice-President Marketing, South Suburban Hospital, 17800 S. Kedzie, Hazel Crest, IL 60429. (9)

FLORA:

Small, progressive hospital in southern Illinois seeks family practitioner. Beautiful small town, scenic area, yet only an hour's drive from major metropolitan areas. Financial assistance and office space available. Contact: John E. Monnahan, Administrator, Clay County Hospital, 700 North Mill, Flora, IL 62839; (618) 662-2131 ext. 228. (9)

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For Brief Summary, please see following page.

DURICEF® (CEFADROXIL)
Penetration plus Duration
in Oral Cephalosporin Therapy

INDICATIONS: DURICEF (cefadroxil) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms: Urinary tract infections caused by *E. coli, P. mirabilis,* and *Klebsiella* species. Skin and skin structure infections caused by staphylococci and/or streptococci. Pharyngitis and tonsillitis caused by Group A beta-hemolytic streptococci. (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. DURICEF is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of DURICEF in the subsequent prevention of rheumatic fever are not available at present.)
Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.
CONTRAINDICATIONS: DURICEF is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.
WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF PENICILLINS AND CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE).
Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil). **Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.** Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated. When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should also be considered.
PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).
DURICEF (cefadroxil) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 ml/min/1.73M²). (See Dosage and Administration section of Prescribing Information.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.
Prolonged use of DURICEF may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.
Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug. DURICEF should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
Usage in Pregnancy: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to 11 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cefadroxil. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.
Nursing Mothers: Caution should be exercised when cefadroxil is administered to a nursing mother.
ADVERSE REACTIONS: *Gastrointestinal*—Symptoms of pseudomembranous colitis can appear during antibiotic treatment. Nausea and vomiting have been reported rarely.
Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug.
Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.
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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ISMS and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

December

Cardiology

Lipoprotein (a): 25 Years of Progress
For: Cardiologists. Symposium: December 2-3, Chicago, IL. **Sponsor:** The University of Chicago School of Medicine, Center for Continuing Medical Education, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** TBA. **Reg. limit:** 150. **Credit:** Category 1: 10 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Neurology

Neurology for the Non-Neurologist
For: Family practitioners, internists, psychiatrists. Lecture/Workshop: December 7-9, Chicago, IL. **Sponsor:** Rush-Presbyterian-St. Lukes's Medical Center, Continuing Medical Education, 600 S. Paulina, Chicago, IL 60612. **Fee:** $400. **Reg. limit:** None. **Credit:** Category 1: 20 hours. **Contact:** Continuing Medical Education. **Phone:** (312) 942-7095.

Obstetrics and Gynecology

Problem Solving in Gynecologic Endocrinology and Infertility
For: Obstetricians and gynecologists. Symposium: December 9-10, Chicago, IL. **Sponsor:** The University of Chicago School of Medicine, Center for Continuing Medical Education, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** TBA. **Reg. limit:** 200. **Credit:** Category 1: 10 hours; ACOG: 10 cognates. **Contact:** Marlene Goldberg. **Phone:** (312) 702-1056.

Ophthalmology

Current Concepts in Pneumatic Retinopexy
For: Ophthalmologists. Symposium/lecture/conference: December 10, Chicago, IL. **Sponsor:** The University of Illinois at Chicago Eye Center, c/o Conferences and Institutes (m/c 607), 912 S. Wood Street, Chicago, IL 60612. **Fee:** $195. **Reg. limit:** 200. **Reg. deadline:** November 23. Credit: Category 1: 7 hours. **Contact:** Sue Talbert, Program Coordinator. **Phone:** (312)996-4631.

Surgery

Hiatus Hernia—Diagnosis and Management
For: Surgeons. **Lecture** (James Harig, M.D., University of Chicago): December 6, DeKalb, IL. **Sponsor:** Kishwaukee Community Hospital, Rt. 23 and Bethany Road, DeKalb, IL 60115; cosponsored by Marion Laboratories. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 1 hour; AAFP Prescribed: 1 hour. **Contact:** K.P. Reddy, M.D. **Phone:** (815)765-1521 x3486.

January

Surgery

Specialty Review in Thoracic Surgery
For: Thoracic, General, and Cardiovascular Disease Surgeons. **Lecture:** January 9-14, 1989, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $705. **Reg. Limit:** None. **Credit:** Category 1: 47 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800)621-4649 in Illinois; (800) 621-4651 outside Illinois.

February

Advanced Trauma Life Support

For: Surgeons and emergency physicians. **Course:** February 17-18, Ann Arbor, MI. **Sponsor:** University of Michigan Medical School, Towsley Center for CME, Ann Arbor, MI 48109-0201. Fee: $595. Reg. limit: 32. **Credit:** Category 1: 18 hours; AOA: applied for. **Contact:** Karen Brown. **Phone:** (313)763-1400 or (800)962-3555.

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Policyholders depend on the Exchange for aggressive defense. Claim examiners direct and monitor the legal team to see that the physician's voice is heard and that the defense is diligent, efficient and speedy. The Exchange continually audits its defense firms to enforce strict performance standards.

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Insufficiency-type fractures should be suspected in post-menopausal elderly women with severe pelvic girdle area pain and no history of trauma. The areas commonly involved are the sacrum and iliac bones in osteoporotic women. Symptoms are often misinterpreted as metastatic lesions. The existence of multiple fractures should suggest insufficiency-type stress fractures. Computed tomography can exclude the presence of a destructive lesion and an associated soft tissue mass such as would appear in metastatic disease. Plain films rarely show these fractures. Bone scan and tomography abnormalities in the sacral and iliac areas suggestive of these insufficiency-type stress fractures make bone biopsies unnecessary. (Hauge, M., *et al:, Mayo Clin Proc* 63:8,807-12, 1988)

In patients with a history of back problems, increased fitness and improved body mechanics decrease the use of health care services and recurrence of back disorders. One-hundred-twenty patients admitted to a community hospital because of low back syndrome were divided into two groups. The control group received conventional medical care and the experimental group received six three-hour sessions of lectures on anatomy, physiology, body mechanics, posture, stress recognition and management, physical exercise, pain relief, and first aid techniques. Patients on this program showed immediate gains in physical strength, mobility, body mechanics, and self-care knowledge. One year later original gains in physical strength and mobility had been maintained. (Morrison, G., *et al.; Arch Phys Med Rehabil* 69:8,605-9, 1988)

Chronic fatigue in ambulatory primary care was noted in 24% of patient visits. For women, this figure was 28%, compared to 19% in men. Clinical, psychometric, laboratory and functional data was gathered. Laboratory testing in 102 fatigued patients and 26 controls was not useful in detecting unsuspected medical conditions. Depression, somatic anxiety or both was noted in 80% of the fatigued patients and in 12% of the control group. The Sickness Impact Profile of 11.3 for fatigued patients was similar to the profile rating reported for patients with major medical illnesses. One year later only 28% of the fatigued patients had improved. (Kroenke, K., *et al.; JAMA* 260:7,929-34, 1988)

The authors conducted a meta-analysis of the combined results of ten randomized clinical trials evaluating the benefits of cardiac rehabilitation following myocardial infarction. The pooled odds ratio for cardiovascular death was significantly lower in the rehabilitation group than in the control group. There was no statistical difference for nonfatal recurrent myocardial infarction between the rehabilitation and the control groups. (Oldridge, N., *et al.; JAMA* 260:7,945-50, 1988)

Vertebral tuberculosis is the most common skeletal type of tuberculosis. The incidence is approximately 1% in tuberculous patients. Predisposing factors are low socioeconomic status, immunosuppression or chemotherapy. Radiographic differentials to be considered are pyogenic spondylitis and tumors. Occasionally, the x-rays may manifest disc space narrowing, calcified abscesses, variable bone destruction, or well defined osteopenic lesions. (Singer, J., Sundaram, M.; *Orthop* 11:2,1222-4, 1988)

Bacterial vaginosis is a polymicrobial, superficial vaginal infection caused by an increase in anaerobic organisms and a concomitant decrease in lactobacilli. Current or previous trichomonas organisms, increased sexual activity and intrauterine devices are risk factors. The condition is usually asymptomatic but could be associated with morbidity in pregnant women. Assessment of cure with metronidazole 500mgm orally for seven days is achieved by gram stain and not by clinical findings. Treatment of sexual partners may be indicated. (Weaver C., Mengel M.; *J Fam Pract* 27:2,207-215, 1988)

Young military recruits who smoked during basic combat training had more upper respiratory infections and viral syndromes than nonsmokers. The study of 1,230 male recruits showed an elevated relative risk of 35-50%. Age, ethnicity, urban background, and education did not alter the data. There was no difference in the average time spent in the hospital due to respiratory disease between the smokers and nonsmokers. (Balke, G., *et al.; Ann Int Med* 109:3,198-202, 1988) ◀

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A Look at What Causes Deficits

Overutilization or Inadequate Funding?

BY JUDEE GALLAGHER, J.D./CHICAGO

Why is an HMO suing a multispecialty group for hundreds of thousands of dollars? Their contract made the group liable for a percentage of the deficit in the hospital fund. When the HMO marketed the plan to high risk members, utilization soared and so did the deficits. The group terminated its contract and the HMO filed suit for the money it claims the group owes.

Making physicians directly responsible for deficits is just one way that HMOs shift financial risk to physicians. When deficits in hospital and specialty pools are applied against any surplus accumulated in subsequent years, physicians pay indirectly. Physicians also pay when a percentage of their capitation fee is withheld to pay for deficits in the risk pools.

Are such risk sharing arrangements an effective way to control overutilization? Or are they just one more way that physicians finance medically necessary care because of inadequate funding or planning by the HMO? That depends on how you answer this question: What caused the deficits?

Overutilization. It's one stock answer and places the physician center stage to explain why X number of hospital days or X number of consultations and tests were required. But what if the physician adhered to the HMO's utilization review program, including severity of illness criteria and protocols, and the medical charts do not indicate overutilization?

What went awry? No stock answer comes to mind, but questions do. If the physician plays the lead in controlling access to care, the HMO is both producer and stage manager. Is the benefit design consistent with the premium? Where do the utilization rates come from? Do they accurately account for the peculiar demographics of the plan? What about the marketing techniques? Was the plan *oversold,* so that members have been encouraged to overutilize services? Were the risk sharing pools adequately funded to begin with? HMOs generally do pay half or more of the deficit in risk sharing pools. But should physicians be liable for a portion of the deficit when the HMO did not adequately budget for specialty and hospital care at the outset?

All contracts should be carefully examined to determine what the financial exposure is. Are physicians required to pay (directly or indirectly) for deficits? Has any physician or physician's group ever received a dollar back from the risk-sharing pool? How is the HMO accountable for unrealistic target utilization rates? Generally speaking, your risk under capitation systems diminishes as the number of members assigned to you increases. Is your participation in risk arrangements contingent on a minimum number of members being assigned to you?

Physicians compensated by capitation fees are already 100% financially at risk for the services they provide directly. The acceptance of additional financial exposure should be carefully weighed. ◀

Judee Gallagher, J.D., is a Chicago private practice attorney retained by the ISMS Office of Contractual Services since 1985.



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- Positive direct Coombs' tests have been reported during treatment with cephalosporins
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea) 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever) 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes
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Tocainide-Induced Pulmonary Toxicity

By Carlos S. Subauste, M.D., Frank L. Mikell, M.D., Pradeep S. Kulkarni, M.D., and Jose P. Parcon, M.D./ Springfield

After three weeks of treatment with tocainide, a 63-year-old female developed pulmonary fibrosis, which simulated cardiogenic pulmonary edema. Broncho-alveolar lavage showed 26% neutrophils, 30% lymphocytes, 43% macrophages and 1% eosinophils. Electron microscopy of the lavage revealed macrophages with lamellar and granular membrane-bound inclusions, presumably contained within the lysosomes.

After tocainide was discontinued and high-dose steroid therapy was started, the patient showed significant clinical and roentgenographic improvement. Electron-microscopic findings suggest a drug-induced phospholipidosis caused by an amphiphilic compound such as tocainide. This may be a mechanism by which tocaine produces pulmonary toxicity.

The interstitial lung diseases are a group of disorders of diverse etiology including drug-related toxicity.[1] Tocainide, a recently released Class IB antiarrhythmic drug has been implicated in rare case reports as a possible cause of interstitial lung disease. The drug has been approved by the FDA and has potential for widespread use as an antiarrhythmic agent. We recently diagnosed a patient with interstitial lung disease caused by tocainide and report this case to emphasize the possibility of severe pulmonary toxicity with the drug. We describe histologic findings in the lung which may relate to a potential mechanism of the pulmonary injury.

A 63-year-old white female who had been a previous smoker developed symptomatic ventricular tachycardia two weeks following a myocardial infarction, despite procainamide therapy. Tocainide was then utilized and the dose increased from 200mg every eight hours to 600mg every eight hours with good control of the arrhythmia. Chest x-ray at this time showed no active pulmonary infiltrates or congestive failure. After three weeks of tocainide therapy, dyspnea and cough developed, without fever. Chest x-ray at her local hospital suggested congestive heart failure, but there was no response to diuretic therapy. On subsequent admission tó our hospital, chest x-ray continued to show extensive reticular and alveolar infiltrates and was interpreted as congestive heart failure. The initial impression was pulmonary edema due to left ventricular dysfunction, but aggressive diuretic and afterload reduction therapy had no effect. Right heart catheterization was then performed and demonstrated normal pulmonary capillary wedge pressure despite continued worsening of her chest x-ray.

Laboratory data revealed a leucocyte count of 15,000, normal differential (no eosinophilia). The serum LDH was 1295IU/L (normal up to 252IU/L) with a peculiar isoenzymatic profile (fractions II and III were increased 2.4 and 9 times over normal, respectively; other fractions were normal). Bone marrow biopsy and CT scan of the abdomen and pelvis were unremarkable. ANA titer was 1:20 and the rheumatoid factor titer was negative. Tocainide levels were not obtained. On a F_IO_2 of 28%, her pO_2 was 33mmHg. Pulmonary function tests indicated severe restrictive lung disease [FVC 1.71Lt (64% pred.), FEV_1 1.38 Lt (62%), FEV_1/FVC 0.8 (95%), $FEF_{25-75\%}$ 1.04 Lt/min (73%)]. Broncho-alveolar lavage showed 26% neutrophils, 30% lymphocytes, 43%

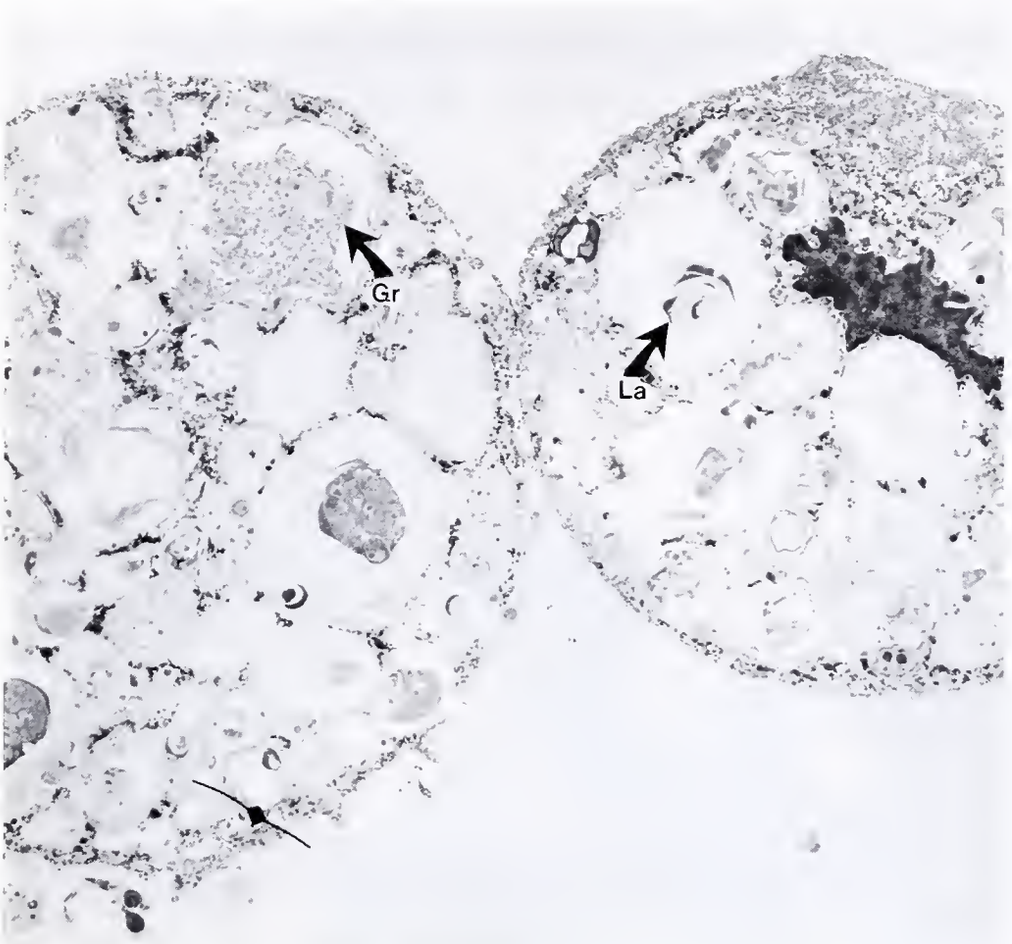


Figure 1
Electron micrograph of the broncho-alveolar lavage showing macrophages with membrane-bound inclusions, presumably contained within the lysosomes. Some inclusions had lamellar structure (La) and other were granular (Gr).

macrophages and 1% eosinophils.

Electron microscopy of the lavage revealed macrophages with lipid droplets and many membrane-bound inclusions felt to be contained within the lysosomes. (Figure 1) Some inclusions had lamellar structures (La) and others were granular (Gr). Histologic examination of an open lung biopsy demonstrated severe interstitial fibrosis, most of which appeared to be in an active phase. There was sparse focal lymphoplasmacytic infiltration with rare neutrophils and eosinophils. Secondary fibromixoid intimal hyperplasia of the pulmonary arteries was observed. No evidence of neoplasm, sarcoid or infection was present.

Hypoxemia persisted for two weeks after stopping tocainide; high dose steroid therapy was initiated. The patient improved clinically and roentgenographically and had better oxygenation (pO_2 of 106mmHg on 32% F_IO_2). Antiarrhythmic therapy with quinaglute 324mg p.o.t.i.d. was initiated after discontinuing tocainide.

Two months after discharge, the patient remained stable and chest x-ray showed continued improvement. The steroid dose was being tapered when two weeks later she died suddenly at home of unknown cause. No autopsy was performed.

This case represents an example of tocainide-induced interstitial lung disease and emphasizes important clinical and histologic information. Because the drug is most likely to be used in patients with underlying cardiac disease and left ventricular dysfunction, interstitial lung toxicity may masquerade as pulmonary edema of cardiac origin. This underscores the need to consider primary interstitial lung disease in patients on this drug in whom apparent congestive heart failure develops, particularly if there is no improvement with standard treatment.

Although previous reports of tocainide-induced pulmonary toxicity have demonstrated interstitial pneumonitis,[2,3,4] the current information on cytoplasmic inclusion bodies has not previously been described. Amiodarone, an amphiphilic drug (nonpolar ring system and a hydrophilic cationic side chain),[5] produces membrane-bound intralysosomal inclusions in macrophages, type II pneumocytes, interstitial cells and endothelial cells.[5] Amphiphilic compounds produce a deficit of lysosomal enzymes phospholipase A and phospholipase C[6] and sphingomyelinase, causing[7] a drug-induced phospholipidosis. Tocainide is also an amphiphilic drug,[8] and this mechanism or, perhaps, immunological abnormalities such as the ones described in amiodarone-induced pulmonary toxicity[9,10] could explain the pulmonary fibrosis caused by tocainide. Unfortunately, drug levels were not obtained in our patient or in other case reports of tocainide-induced pulmonary toxicity. Thus, it is uncertain if this toxicity relates to blood levels of the agent.

Physicians using tocainide need to be aware of the possibility for pulmonary toxicity and monitor patients accordingly. If detected early, before pulmonary fibrosis is advanced, steroid therapy may be of potential benefit.[2,3,4]

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Malignant Fibrous Histiocytoma of the Lung

By Arthur S. Palmer, M.D., John M. Passmann, M.D., Ph.D., and Jesus G. Vega, M.D./Chicago

Malignant fibrous histiocytoma was initially described by O'Brien and Stout in 1964.[1] It usually occurs in the extremities and retroperitoneum, and may metastasize to the lung. Primary occurrence in the lung is rare. We review the literature and report an additional case.

A 62-year-old female smoker was admitted for evaluation of a mass in the right lung present on x-ray two months earlier and which had shown significant enlargement. (Figures 1 and 2)

A right thoracotomy with right lower lobectomy was performed. The patient had an uneventful postoperative course. On histologic examination, the tumor was found to be a malignant fibrous histiocytoma. The hilar lymph nodes were negative for metastatic disease.

This patient was readmitted two months later with an episode of transient confusion. A right frontal mass was noted on computerized tomography, and a craniotomy was performed for excision. At this time, she was started on chemotherapy. Three months later craniotomy was repeated and recurrent tumor was noted in the same area. She continued on chemotherapy and expired nine months later (14 months after pulmonary resection).

Autopsy revealed metastatic disease in the right ventricle of the heart, the right frontal lobe of the brain, the liver, the stomach, and both lungs. The metastasis to the right ventricle was large, measuring 8.5 × 4.5cm. It was located in the right ventricular outflow tract below the cusps of the pulmonary valve. The cause of death was most likely obstruction of the right ventricular outflow tract by the metastatic tumor.

Histologic Findings

The primary tumor and metastases were composed of plump spindle cells in a predominant storiform pattern. Numerous normal and abnormal mitotic figures were present. Small numbers of histiocytoid cells and some xanthoma cells

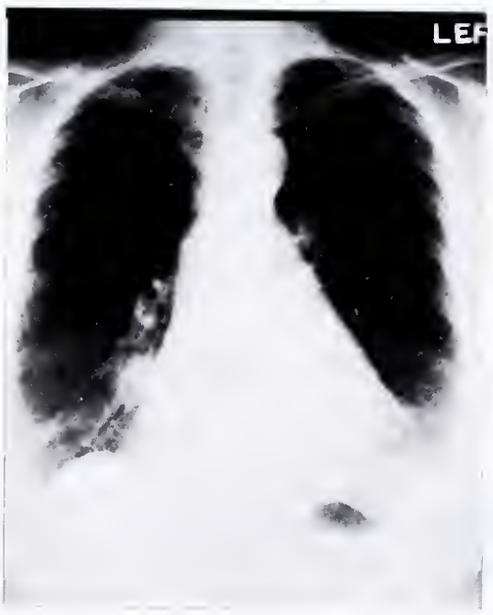


Figure 1
Chest film taken at time of admission. Note tumor adjacent to the right heart border.

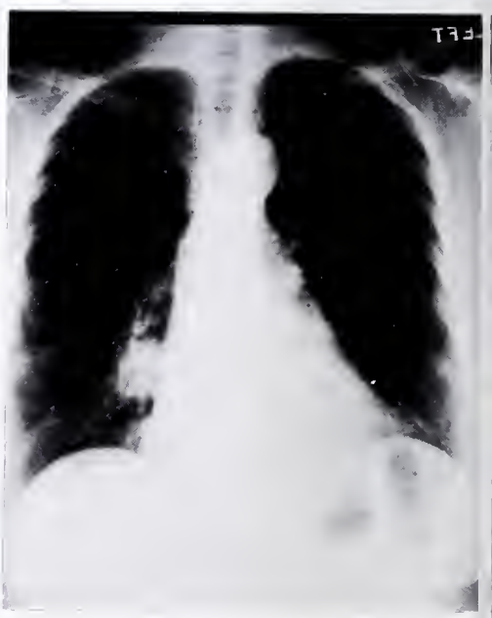


Figure 2
Chest film taken two months prior to Figure 1. Note significantly smaller size of tumor.

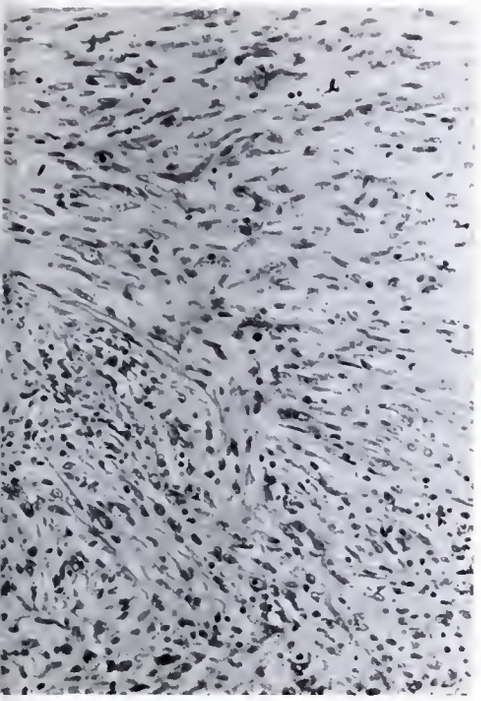


Figure 3
Low-power view of tumor showing plump spindle cells in storiform pattern.

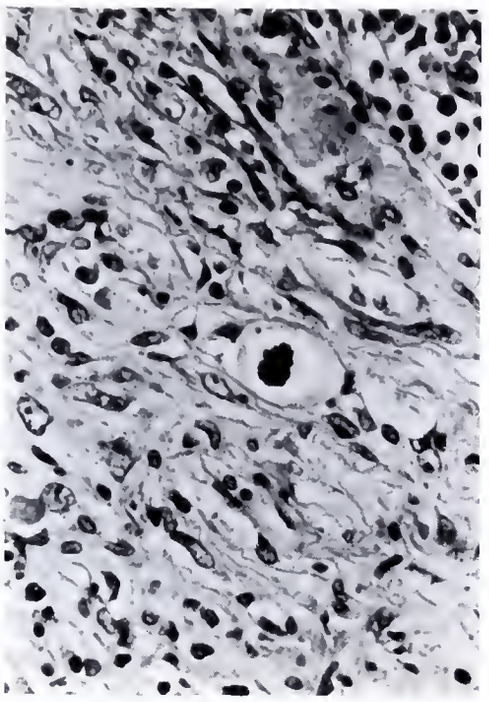


Figure 4
High-power view of tumor.

were also present. Cellularity varied and included some foci composed of a storiform arrangement of delicate collagen fibrils with scant cells. Numerous foci of necrosis were seen. (Figures 3 and 4)

Discussion

The initial report of malignant fibrous histiocytoma of the lung was made in 1979 by Bedrossin, *et al.*[2] This occurred in a 51-year-old man, and was noted in both lungs on initial chest x-ray. Only one of these lesions was removed, and the patient expired one year after the initial surgery. A subsequent report by Kern, *et al.*[3] described two additional patients, a 53-year-old male and a 25-year-old female. Both were resected; however, both developed early cerebral metastases. Another case was described by Chowdhury, *et al.*[4], and a fifth case was described by Mills.[5] This patient developed metastatic disease in the sternum, which was noted sixteen months after her initial resection, and for which she received radiation. Two additional cases were described by Venn, *et al.*[6]

Of the eight reported cases, six developed early metastatic disease. The brain was a common site for metastases. The interesting features of this case were the rapid growth demonstrated on the two preoperative chest x-rays, and the early appearance of metastatic disease. In view of this, an early aggressive search for metastasis, especially in the brain, should be made on initial diagnosis.

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Surgical Management in a Young Child

Synchronous Cystic Hygromas

By Carl Davis, Jr., M.D./Chicago

Cystic hygroma is a congenital lesion which arises in the sites of primitive lakes. It is soft and spongy, varies in size and shape, and may present with a honeycombed appearance due to its multilocular, thin-walled, endothelial-lined spaces filled with clear or amber-colored fluid. Cystic hygroma may be present early in life. Complete surgical excision is recommended to avoid untoward complications such as respiratory and aspiration problems, dysphagia or infection. Ravitch stated that the "uncomeliness of this swelling, the inconvenience it causes, its likelihood to infection, its tendency to growth and extension, all constitute reasons for surgical removal of these cysts."[1]

Resection of cystic hygromas often results in a vascular, time-consuming dissection because parts of the tumor may ramify between muscles as well as engulf major blood vessels and nerves. Surgical intervention of these cases can provide a challenge to the most experienced surgeon. More than one operation may be required to completely remove this cystic tumor because of the difficulty of total excision at the time of the first resection.[2,3]

Case Report

A 20-month-old female presented with a large, supraclavicular swelling of the right side of the neck and a smaller mass in the right axilla. (Figure 1A) Neither tumor was observed at birth. Roentgenograms of the head, as well as of the chest, demonstrated a well-outlined

Figure 1



Figure 1A
Note the cystic hygroma in the cervical region (arrow) and the cystic hygroma in the right axilla with no evidence of communication between the two.



Figure 1B
This surgical specimen represents the intact cystic hygroma removed from the neck.

Figure 2



Figure 2A
Note the rapidly-expanding cystic tumor in the axilla.



Figure 2B
This roentgenogram demonstrates a large soft tissue lesion in the axilla without evidence of intra-thoracic extension.

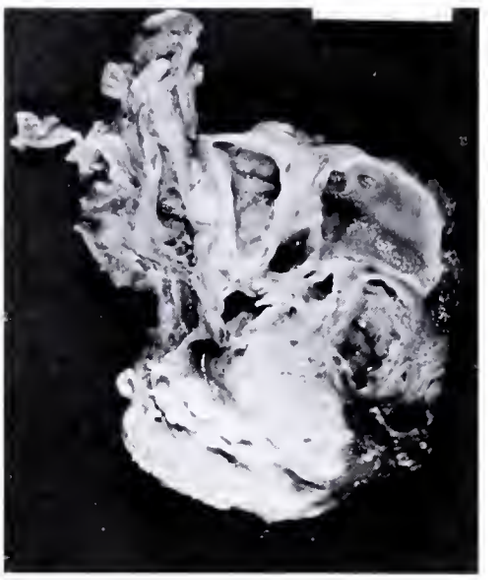


Figure 2C
This illustration demonstrates the cut surface of one half of the axillary hygroma. The entire surgical specimen measured 10 × 8cms and weighed 120gms.

soft tissue lesion in the cervical region and a similar one in the right axilla. No evidence of any communication between the two cystic hygromas existed on x-ray.

At the initial operation, under endotracheal anesthesia, excision of a well-defined cystic hygroma of the neck was accomplished through a transverse incision. The postoperative course was uncomplicated. Pathological examination was consistent with a multilocular tumor characteristic of a cystic hygroma. (Figure 1B)

Three months later, the child returned with a rapidly-expanding swelling in the right axilla. (Figure 2A) A chest film demonstrated a mass in the axilla without evidence of intra-thoracic extension. (Figure 2B) At a second operation, under endotracheal anesthesia, the removal of a large cystic tumor in the axilla was accomplished through a posterior-lateral incision. Resection of numerous finger-like projections of this lesion, which encircled the axillary vessels and the brachial plexus, prolonged the operative procedure. The patient responded well, without complications; postoperative course was uneventful. The gross and histologic findings were compatible with a large cystic hygroma. (Figure 2C)

At this writing, four years postoperatively, there is no evidence of recurrence of either the cervical or axillary hygroma.

Discussion

Many theories of the origin of cystic hygroma have been advanced in the literature since Radenbacher first used the term in 1829 to describe these lesions.[4] Complete obstruction of lymphatic vessels produces defects which vary from the common cystic hygroma to extensive lymphangiomyomatosis. The embryological basis for their development and pathology is similar.[5,6] Although cystic hygroma may appear quite different clinically from cavernous lymphangioma, there is no sharp dividing line between the two.[7]

In past years, numerous modalities were recommended in the management of cystic hygroma, including aspiration, injection of a sclerosing solution, use of radon seeds, partial or complete resection and irradiation therapy.[8-13] However, irradiation is currently not advised because of the risk of malignancy in the thyroid gland and its ineffectiveness compared to surgery.[14] Today, early, complete surgical excision of a cystic hygroma, even in the neonate, is the preferred treatment.

In a large series reported by Saijo, *et al.*, of the Mayo Clinic, it was pointed out that excision of all involved tissue cannot guarantee complete removal. The surrounding invasion is sometimes more extensive than the lesion would suggest; however, if feasible, the most complete surgical excision possible is recommended.[15]

W. J. Potts of Chicago stated some years ago that the surgical objectives of cystic hygroma are relief of obstruction on vital structures and a good cosmetic result. He added that "good judgment must control the extent of the operation".[16]

Summary

Surgical management of synchronous cystic hygromas in a twenty-month-old female was described. Initial resection of a large cystic hygroma in the cervical region was performed without incident. After three months, a huge, rapidly-expanding axillary hygroma was removed successfully without complication. At this time, four years

postoperatively, the child shows no evidence of recurrence of either lesion.

It is suggested that a cystic hygroma (a benign lesion of the lymphatic system) is best treated, even in the neonate, by surgical extirpation shortly after recognition. This avoids local expansion and subsequent complications. Because these lesions infiltrate local tissues, surgical excision is often vascular, prolonged and tedious, and may prove to be a challenge to the more experienced surgeon.

More than one operation may be required to remove the entire hygroma because of the difficulty of total excision at the time of the first resection. ◀

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Presenting As Acute Myocardial Infarction

Myocarditis

By Jay A. Riseman, M.D., George J. Taylor, IV, M.D., and Donald R. Graham, M.D./Springfield

A young man presented to the hospital with diagnosis of possible myocardial infarction. He had been healthy up to shortly before admission, when he developed "flu-like" symptoms. Electrocardiogram was consistent with myocardial infarction and cardiac enzyme elevations were consistent. Coronary arteriogram, however, was normal. Coxsackie B viral antibody titers were obtained and were consistent with acute infection. The patient recovered fully with conservative therapy of aspirin and limited activity.

In adults, Coxsackie myocarditis is usually an acute, self-limited, benign illness.[1] Coxsackie B is considered the most common viral etiology of myocarditis.[2] Gardines and Short reported four different groups of acute myopericarditis, including myocarditis, which mimics myocardial infarction (MI).[3] Viral myocarditis, especially when caused by Coxsackie virus, is nearly always associated with pericarditis, and for this reason is called myopericarditis. In one study, 10% of subjects with clinical symptoms, Q-waves, and typical cardiac enzyme elevations compatible with acute MI had concomitant fourfold increases in Coxsackie B neutralizing antibody titers.[2] Finally, viral infection causes congestive cardiomyopathy and chronic valvular disease.

We describe a patient with clinical features of MI. He had suggestive EKG changes and laboratory proof (enzymes) of localized myocardial insult. No obstructive disease was demonstrated by coronary angiography. We concluded that his illness represented viral infection.

Case Report

This 22-year-old man was in good health with no previous cardiac symptoms. Four days before admission, he developed nausea, vomiting, fever, postnasal drip, nonproductive cough, and myalgia. His local physician prescribed erythromycin. He awakened early the next morning with sharp gripping chest pain in the anterior left chest radiating to the left arm, and with associated nausea, diaphoresis and mild dyspnea. The pain lasted seven hours and was finally relieved by morphine at a rural hospital, where, after admission, he was noted to have ventricular paroxysmal beats and ventricular tachycardia requiring lidocaine. A second episode of chest pain prompted his transfer to our institution.

Past medical history was unremarkable. His father had died early of MI. Examination revealed a temperature of 38°C, yellow mucinous drainage in the posterior pharynx with mild erythremia, mild cervical adenopathy, clear lungs, and heart without murmurs, gallop, or rub.

Creatine phosphokinase (CPK) peaked at 1920U/L (0-200) the evening of the first hospital day, 19 hours after the original chest pain. CPK-MB was 129ng/ml (0-2.0). EKG showed normal sinus rhythm with ST elevation in leads V_2-V_6. Chest x-ray revealed only old granulomatous disease. Westergren sedimentation rate was 58mm/hour. He had a leukocytosis with left shift. Chemistries were all normal except for an LDH of 388 (0-246) and an SGOT of 109 (0-33). Admitting diagnosis was myocardial infarct.

Echocardiogram showed a mild increase in left ventricular size with fair systolic function. Cardiac catheterization and coronary arteriography demonstrated normal coronary arteries, mild left ventricular dysfunction, elevated left ventricular end diastolic pressure and a slightly reduced ejection fraction (45%).

CPK levels fell to 451U/L by the third hospital day. Acute viral serum antibody titers of 1/64 against Coxsackie B type 6 and convalescent serum titer three weeks later of 1/8 were measured by neutralization technique. All other enteroviruses and other common adult respiratory virus antibody titers were negative.

The patient was discharged on the fifth day to take aspirin 650mg three times daily and avoid heavy work for one month. At that time he returned to normal activity with good exercise tolerance.

Discussion

Coxsackie virus infections are prevalent in summer and early fall and commonly occur in epidemics.[4] The viruses are members of the picornavirus family, and are included in the genera of enteroviruses with polio and the ECHO viruses. All can cause systemic infection after ingestion and replication in the gastrointestinal tract.[5] Coxsackie B is especially cardiotropic in man and is the most common cause of viral heart disease.[5]

Common symptoms of viral myocarditis include chest pain, myalgia, syncope, weakness, fatigue, shivering, and nausea. Less frequently reported have been coryza, sore throat, cough, dyspnea, headache and diaphoresis. Physical signs include tachypnea, fever, tachycardia, pericardial rub, murmurs, gallops, and jugular venous distention. Pleurodynia, arrhythmias, congestive heart failure and pleural and pericardial effusions are also common.

Although infection may occur at any age with this agent, the incidence of Coxsackie viral heart disease is highest in two groups: infants and young adults. The highest incidence of disseminated disease and the greatest mortality occurs in patients below one year of age, especially neonates. In the second group, ages 10-30 years, the disease is usually benign. The disease commonly affects men more than women.

Woodruff suggested several approaches to viral diagnosis, including isolation and identification, direct tissue examination, and serologic evaluation.[5] Most of these techniques require a long period of time and are not readily available. Electron microscopy is being employed with increasing frequency for rapid diagnosis of viral disease.[6]

Differentiating myopericarditis from acute myocardial infarction can be very difficult.[7] Both have been associated with EKG changes such as ST elevation, T-wave inversions and abnormal Q-waves.[7] Creatine kinase myocardial band (MB) levels have also been elevated. Ventriculography, echocardiography and scintigrams have all shown localized myocardial dysfunction in myocarditis, as well as in myocardial infarct. Chest x-ray has shown heart enlargement in both. Our patient could have been diagnosed with acute MI, but after aggressive diagnostic procedures such as cardiac catheterization and ventriculogram, myocarditis became a more probable diagnosis.

One aggressive method was described by Fenoglio[8], in which myocarditis was diagnosed by endomyocardial biopsy. The study suggested that patients could be divided into three groups based on clinical and histologic findings. Members of the first group, acute myocarditis, were young, with a clearly male majority and a history of viral-like illness one to three weeks before presentation. The next group, rapidly progressive myocarditis, was generally older, but also mostly male. The last group, chronic myocarditis, was in-between the above age groups and mostly female. In retrospect, the histologic findings had a 94% correlation with the clinical presentation of myocarditis.

In our patient myocarditis presented as a self-limited, benign illness. It can, however, pursue a subacute or chronic course leading to permanent cardiomyopathy or death.[1] Myocarditis has been reported in up to ten percent of routine autopsies. The time incidence of acute viral myopericarditis is unknown due to the difficulties of establishing the diagnosis and the specific viral agent.[5]

Mechanisms of cardiac injury are still theoretical. The strongest evidence is that immunological mechanisms are involved in the resultant myocardial necrosis and inflammation.[9] Two other mechanisms are direct myofiber necrosis and myofiber contractile abnormalities resulting from infection and replication of the virus.

Conclusion

Physicians examining young adults who develop acute chest pain should be alert to several possibilities, including MI and myopericarditis. As stated by James, "It may be fair to say that today myocarditis encountered in clinical practice is not caused by viruses as often as the clinician suspects, but is probably caused more often than virologists and others can currently prove."[10] Viral diagnostic techniques are becoming more sophisticated, leading to a greater number of correctly diagnosed cases in the future.

Although Fenoglio found immunosuppressive therapy helpful in a select group of patients, the best hope for the future lies in an increased understanding of the infectious agents responsible for myocarditis. Better identification of the organism and specific treatments will improve the prognosis for patients with myocarditis and may also possibly eliminate some important causes of cardiomyopathy. ◀

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Presenting as High Output Heart Failure

Hypernephroma

By Mary Jo Gorman, M.D. and Wilfred Lam, M.D./Springfield

A 75-year-old woman presenting with congestive heart failure with preserved left ventricular systolic function was found to have high output heart failure at cardiac catheterization and evidence of a possible systemic shunt originating below the diaphragm. Investigation showed the presence of abnormal left renal vessels and mass. At surgery, a hypernephroma was found which did not present with pain, palpable mass, or abnormal urinalysis. In this case, a hypernephroma was discovered because of high output heart failure with an absence of urinary symptoms.

High output heart failure has been a well-described clinical entity secondary to hypermetabolic states of hyperkinetic conditions such as anemia, hyperthyroidism or AV fistulas. Physiologically, these conditions produce reduction in after-load and augmentation of venous return, leading to increased volume load on the heart. Although it is well known that many tumors can have abnormal vascularity, high output heart failure has been described in very few malignancies. We present a case of high output failure as a presenting manifestation of hypernephroma.

Case Report

A 75-year-old female presented with a three-week history of congestive heart failure, including increasing edema, dyspnea on exertion, orthopnea, and paroxysmal nocturnal dyspnea. She had a history of hypertension and had been receiving labetalol 100mg daily. Her history did not include ischemic heart disease or heart murmurs.

Examination revealed a blood pressure of 160/70 and a pulse of 70. She was afebrile and had clinical evidence of congestive failure with neck vein distention, rales in the lower half of the lung fields posteriorly, and a grade III/VI midsystolic murmur at the apex. There was no hepatomegaly and there was 2+/4+ pitting ankle edema. Chest x-ray demonstrated cardiomegaly with congestive heart failure. An EKG showed PACs and right bundle branch block. The patient exhibited a mild anemia with a hemoglobin of 10.9 grams percent. Urinalysis was completely negative and thyroid studies were normal.

The patient's hospital course consisted of treatment of heart failure with digoxin and furosemide. Over several days, she diuresed, with improvement of symptoms and clearing of physical findings of congestive failure. An echocardiogram demonstrated a normal size LV with good contractility suggesting volume over-load and a radionuclide ejection fraction of 53%. After diuresis and compensation of heart failure, cardiac catheterization demonstrated normal pulmonary capillary wedge pressure with a V wave of 35mmHg, LV pressure of 220/16, and otherwise normal right heart pressures. Oximetry demonstrated a high pulmonary artery oxygen (O_2) saturation of 82%, with right atrial saturation averaging 88%, SVC saturation of 64% and IVC saturation of 90.5%. Cardiac output was 5.2 liters per minute and the AV O_2 difference was 2.2 volumes percent.

There was no evidence of intracardiac shunting by angiography at the ventricular, aortic or atrial level. There was mild mitral regurgitation with normal LV systolic function. Coronary arteriography showed significant narrowing of the origin of a nondominant, right coronary artery only.

Aortography demonstrated no aortic insufficiency, but the evidence existed for rapid transit of contrast dye into the left renal vein via abnormal vessels in the left kidney, with early filling of the inferior vena cava. Catheterization demonstrated some evidence for hypertensive heart disease and coronary dis-

ease, but the patient appeared to have high output heart failure with evidence of a reduced AV O_2 difference secondary to apparent angiographic shunting via the left kidney.

In view of the catheterization findings, a CT scan of the abdomen was performed. It demonstrated a left renal mass consistent with hypernephroma. Subsequently, a left nephrectomy confirmed the diagnosis of a hypernephroma which had not metastasized or extended past the renal capsule, although there was evidence of tumor thrombosis in the left renal vein which was dilated to 1.2cm in diameter.

Discussion

The concept of high output heart failure has been well described and usually implies a normal or above-normal cardiac output with clinical failure. In the absence of anemia, this usually results in a reduced AV O_2 difference and is seen classically in such states as hyperthyroidism or an arterial venous fistula. Other causes of high output failure described in the literature include Paget's disease, Albright's syndrome, beriberi, and carcinoid syndrome.[1] Hemangioma has been described as causing high output failure in children, but, in a review of the literature, only two cases of cardiac failure have been associated with malignancies. Tamir, *et al.,* described a case of high output failure as the presenting symptom of a plasma cell leukemia.[2] Ho, *et al.,* described a case of an hemangiosarcoma of the liver also presenting as high output failure.[3]

Our patient had mild hypertensive heart disease and minimal coronary artery disease presenting with right- and left-sided heart failure. She was found to have a normal cardiac output with reduced AV O_2 difference and high mixed venous O_2 saturation in the absence of an intracardiac shunt. There appeared to be shunting of blood angiographically in the left kidney and further studies confirmed that the patient had a hypernephroma. No clinical evidence existed otherwise to suggest a hypernephroma. The patient had a normal urinalysis with no evidence of abdominal mass on examination.

After removal of the tumor, no treatment with digoxin or diuretics was given. The patient had no recurrence of congestive failure. Classically, a hypernephroma presents with hematuria, pain, and a palpable mass, but it is not uncommon for these findings to be absent. Rarely, a hypernephroma presents as a fever of unknown origin.[4] Angiographically, hypernephromas usually have dilated vessels, with AV shunting in the vasculature of the neoplasm in 90% of cases.[5] It would not be unexpected for a patient with hypernephroma to have a high cardiac output. Nevertheless, at this writing, this has not been described in the literature as a cause of high output heart failure.

In patients presenting with clinical heart failure with normal LV systolic function, consideration must be given to high output failure as either the cause of or an aggravating factor in congestive heart failure. In this setting, a right heart catheterization may be appropriate to document a narrow AV O_2 difference with no evidence of intracardiac shunting. ◀

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Into the Pleural Cavity

Misplacement of the Narrow-Bore Feeding Tube

By Joong H. Choh, M.D., Muhammad Riaz, M.D., H. Jae Ihm, M.D., Chilakamari Yeshwant, M.D., and A. Hassan Khazei, M.D./Elgin

In an 81-year-old, female patient with aplastic anemia, pseudomonas sepsis and respiratory failure, the narrow-bore feeding tube was misplaced transbronchially into the right pleural space. The inadvertent misplacement of the tube was immediately diagnosed by chest x-ray and bronchoscopy. The patient was promptly treated by a chest tube insertion without undue sequelae.

Insertion of the narrow-bore feeding tube with guide wire can be difficult and dangerous in patients with impaired cough reflexes and altered airway, such as endotracheal or tracheostomy tube.

Alternate methods of insertion or different types of feeding tubes should be considered in such cases. Chest x-ray should be taken after insertion of any feeding tube to confirm its position.

Nutritional support in critically-ill patients is widely accepted as an essential part of patient care. Enteral feeding through the oral route or a feeding tube is generally considered to be superior to intravenous hyperalimentation in patients with adequate gastrointestinal function.

This concept recently brought popular acceptance of the small-bore, highly flexible nasogastric feeding tube. However, the extreme flexibility of this thin feeding tube makes its insertion very difficult in those patients who are unable to swallow.

To overcome this difficulty, wire stylets were added to the feeding tube to stiffen it.

We report a serious complication caused by insertion of the narrow-bore soft feeding tube with wire stylet. The feeding tube was inserted inadvertently through the right bronchial system into the right pleural cavity. Immediate recognition of the complication and proper management prevented a further catastrophic complication.

Case History

An 81-year-old female with a history of aplastic anemia and diabetes mellitus was admitted with severe bilateral pseudomonas pneumonia. In spite of antibiotic treatment, the patient developed progressive respiratory failure and pulmonary edema, for which an endotracheal tube was inserted. She was placed on a ventilator. Because of persistent difficulty to wean her from the respirator, a tracheostomy was done eight days after the endotracheal intubation.

In order to maintain nutritional requirements, enteral hyperalimentation was suggested. A narrow bore feeding tube with a wire stylet was inserted through the right nostril by an ICU nurse, who felt some resistance during the insertion. Chest x-ray was ordered, which showed the tip of the feeding tube in the right pleural cavity. The course of the feeding tube appeared to follow the trachea and right bronchial tree. (Figures 1A and B) The problem was immediately recognized and a thoracic surgeon was consulted.

Fiberoptic bronchoscopy through the nasopharynx and



Figure 1A
Anteroposterior chest x-ray shows the misplaced feeding tube in the right pleural cavity.



Figure 1B
Lateral chest x-ray shows the misplaced feeding tube following the course of tracheobronchial tree.

through the tracheostomy tube confirmed intrabronchial placement of the feeding tube, disappearing through the medial basal segmental bronchus of the right lower lobe. The feeding tube was removed immediately.

Because the patient required a PEEP treatment on the respirator and chest x-ray showed pleural fluid, a right chest-tube was inserted.

The respiratory condition of the patient gradually improved with antibiotics and intensive respiratory care. Four weeks later, the trancheostomy tube was removed. She was sent home in good general condition after eight weeks of hospitalization.

Discussion

Enteral hyperalimentation is generally considered safer, less expensive and more physiologic than intravenous hyperalimentation,[1] especially if the patient has an intact gastrointestinal tract. The use of an enteral route has become more popular by the introduction of small-bore, highly flexible nasogastric tubes which increase patient acceptance.

However, in patients who are intubated either with a cuffed endotracheal tube or a tracheostomy tube, there is an increased risk of nasogastric tubes being misplaced into the tracheobronchial area. Accidental passage of nasogastric tubes or esophageal monitoring devices into the lung or pleural punctures has been described.[2-7]

We have noted increased frequency of difficult nasogastric tube insertion in the intensive care unit of our hospital, especially in patients with altered consciousness or abnormal cough reflex. Increasing use of the plastic endotracheal or tracheostomy tubes with low pressure cuff appears to be related with this increased difficulty.[2]

Although the introduction of the small-bore, flexible nasogastric tube gained wide acceptance because of greater patient comfort, it is generally more difficult to insert the tube in the intubated patient or the patient with altered consciousness.

In order to overcome this difficulty, wire stylets are frequently used to stiffen these soft tubes for blind insertion, especially in patients unable to swallow.

Recently, perforation of the lung and pleura by the newly-developed, soft, narrow-bore feeding naso-gastric tube has been reported.[4] Our experience confirms this serious complication and the possibility of tragic outcome.[6]

We agree that the smaller diameter and softer characteristics of the tube may provide greater patient comfort and acceptance. However, these unique features necessitating the use of a wire stylet may facilitate inadvertent passage of the nasogastric tube into the tracheobronchial tree.

It should also be noted that most of the patients with this complication showed impaired cough and gag reflex and frequently had altered consciousness.

Fatal hydrothorax and empyema have also been reported with this complication.[6] With increasing reports of the inadvertent misplacement of the nasogastric tube,[2-7] we recommend extreme caution be exerted by any personnel inserting the tube.

Routine methods of confirming the tube placement such as auscultation of the left upper quadrant after air injection or aspiration of gastric contents are not sufficient. An x-ray should be taken following the insertion of a nasogastric tube and feeding should never be started before confirmation of the tube position.

In our case, use of a simple portable chest x-ray before feeding prevented any further serious complication such as empyema thoracis or bronchopleural fistula.

Addendum

Since the preparation of this manuscript, we have experienced two additional cases of misplacement of the feeding tube using the same type of feeding tube and accompanying stylet as described here.

An 85-year-old female, who was originally admitted with mild congestive heart failure, eventually died from massive right hydropneumothorax and empyema thoracis related to the misplacement of the feeding tube into the right chest.

A 76-year-old male who underwent an emergency triple coronary bypass received postoperative nutritional supplement through the misplaced feeding tube. The patient required a prolonged hospitalization of eight weeks, and required multiple chest tube insertions of the right thorax for drainage of the empyema. ◀

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SPECIAL ARTICLE

A Pioneer Illinois Physician and Scholar

John F. Snyder, M.D.

BY EMMET F. PEARSON, M.D./SPRINGFIELD

Dr. John Francis Snyder distinguished himself among his peers through his extraordinarily diverse and illustrious career. An early Illinois physician and scholar, Snyder also proved himself to be a well-educated and capable lawyer, a successful politician and state legislator, archeologist, historian and naturalist. He truly exemplifies the best in the pioneering spirit and ability of great Illinois men in the late nineteenth and early twentieth centuries.

John Francis Snyder was born in Cahokia, Illinois, on March 22, 1830. He was a great-grandson of Captain Jean-Baptiste Saucier, formerly a cadet at L'Ecole Militaire in Paris. Saucier had been among the original French troops who moved into Illinois in the eighteenth century, and had surveyed and managed the site of the famous Fort de Chartres. For decades the Saucier family men had served France as officers in the military and as astute businessmen. Captain Saucier's granddaughter, the grandmother of John Francis, married Adam Snyder, an Alsatian immigrant who fought in the American Revolution and then settled in Pennsylvania. Adam Snyder's son, also named Adam, was born in 1799. The junior Adam Snyder went to Ohio seeking employment when he was eighteen. While in Ohio, Adam met an Illinois judge who offered him a job operating a carding mill in Cahokia, Illinois. So Adam moved to Illinois in 1817 where he became an important politician by his early twenties and studied law. He met and married Adelaide Saucier Perry of the famous Saucier clan.



Photo of John Francis Snyder, M.D., circa 1900. (Reprinted with permission of the Illinois State Historical Library.)

In the 1830s, such a large number of Germans immigrated to the Belleville area that the common language on the streets was German. When John Francis was three, his family relocated from Cahokia to nearby Belleville because they thought the climate was better. Because John's father spoke German, he was immensely popular with the German community and rose rapidly in local politics.

The Snyders enjoyed growing prosperity in Belleville. By the time Adam was elected to Congress in 1836, the family had what was considered the finest house in town, and it proved a natural gathering place for prominent politicians. On one occasion, Stephen A. Douglas and Abraham Lincoln are reputed to have met there. In 1843, John's father, Adam, died suddenly, crushing his party's attempts to place him on the Democratic ticket as a candidate for governor.

John became quite depressed after his father's protracted illness and death. His mother suffered prolonged periods of elation and depression.

John missed the intellectual stimulation his father had provided, but nevertheless, continued his private instruction and showed great interest in political matters. His frequently-published articles in local newspapers were indicative of a fer-

tile mind in a young man.

John attended McKendree College, as did his two older brothers, and enrolled in MacDonald's Medical School in St. Louis in 1849. When he ran out of money, he decided to head west with the Gold Rush. Along with his two brothers and others from Belleville, John travelled to California via the Overland Route, through Santa Fe and on to Sacramento, where they arrived on foot and penniless after four months. Although John began digging for gold, he found the pickings to be slim. During the rainy season he apparently ate and drank too much, and to fill the time became editor of a publication for miners.

Returning to Belleville penniless, John found none of his former friends. Disappointed and full of self-chastisement for his failures, John again departed for California in 1850. This time his luck was a little better. He made all of a thousand dollars and considered himself wealthy. Immensely pleased by his good fortune, John decided to return to MacDonald's Medical School.

Looking for adequate transportation, he first found a boat that was to take him around the "horn" to New York, but missed catching this boat for some reason. His luck was still with him, since that particular vessel was lost and never heard from again. The boat he finally did take went to New York, crossing in only twenty-seven days via Panama. Unfortunately, John contracted malaria in Panama and arrived stateside with severe chills. John did not recover, and in desperation, travelled to Pennsylvania, where he consulted a doctor and stayed with relatives. The fee recorded for the doctor's visit was twenty-five cents. John completed his medical education at MacDonald's in 1853, passed his medical examinations and began practicing in Bolivar, Missouri. There he met the belle of the town, Anne Lisa Saunders, and married her on September 27, 1854.

While in Bolivar, John was active in Democratic politics, served as a colonel in the Missouri militia, and became editor of a local newspaper. Always ambitious, John read law and was admitted to the Missouri bar in April 1859. As a candidate for the Missouri legislature John professed to be against abolition and "all that humbug." With sentiment running in favor of abolition, however, John was defeated in his bid for election.



Mansion House in Belleville in 1842. (Photo reprinted with permission of the Illinois State Historical Library.)

As the antislavery question became more prominent, southern Missouri was divided between those who were in favor of secession and the Union preservationists. John joined the forces of the Southern cause and became a commander of Folk County Rangers along the Missouri border. After the firing at Fort Sumter he was elected Major of the First Battalion of Missouri Confederate Forces. He fought in several important battles, proceeding south as far as the battle in Corinth, Mississippi. By 1863 John could see that the Confederacy was collapsing, so he returned to Bolivar, where he decided to practice law. He had served as a line officer rather than as a surgeon during the Civil War and had been sufficiently disturbed by the performance of military surgeons to choose law over the practice of medicine.

On one occasion, John traveled to Sante Fe to clarify a client's property dispute. He stayed in New Mexico for some months. It was after this time that he decided to return to his native state of Illinois and practice medicine. While he was searching for a good communi-

Returning to Belleville penniless, John found none of his former friends. Disappointed and full of self-chastisement for his failures, John again departed for California in 1850. This time his luck was a little better. He made all of a thousand dollars and considered himself wealthy.

While he was searching for a good community in which to set up practice, he heard from the Democratic contingent in Virginia, a small Illinois town. These petitioners wished to have him in Virginia because "the only good doctor in town was a Republican."

ty in which to set up practice, he heard from the Democratic contingent in Virginia, a small Illinois town. These petitioners wished to have him in Virginia because "the only good doctor in town was a Republican."

Life in Virginia, Illinois, appealed to John, because he remained there the rest of his life. He was elected to the Morgan County Medical Society in 1866 (in Jacksonville) and was given the position of Physician for Cass County in 1890.

John Snyder's memorabilia indicate that he carried on an extensive correspondence with area physicians. Many considered him a great intellect and asked for his advice on medical and philosophical matters. One of the people he corresponded with frequently was Dr. David Prince of Jacksonville, principal founder of the Illinois College of Medicine, the first medical school in Illinois. Dr. Snyder kept a detailed diary, which is now in the Illinois Historical Library, along with much of his voluminous correspondence.

Dr. Snyder's letters to his colleagues contain an abundance of information relative to medical treatment in pioneer Illinois. One letter reveals how he interchanged large healing scabs from smallpox patients to use in vaccination research with David Prince and other area physicians. In practice John did use *Veratrum viride* and red phosphate of mercury, but probably did not prescribe calomel and most certainly avoided phlebotomy. His correspondence leads the reader to conclude that John Snyder was dissatisfied in general that most medicines prescribed were more or less of an empirical nature and lacked the stamp of scientific logic in their use.

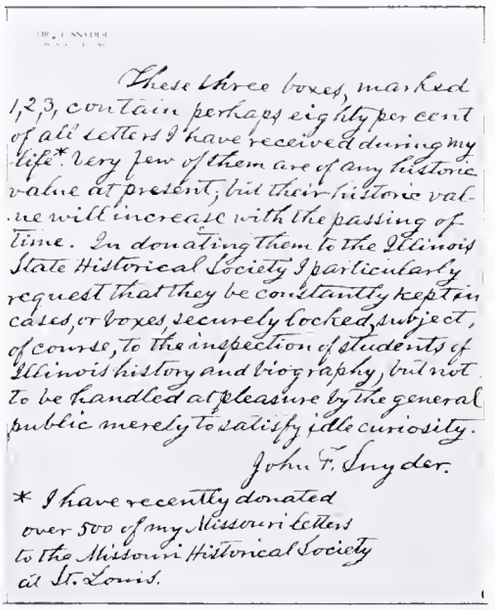
Snyder's medical practice provided sufficient income to permit him to indulge in disparate pursuits, from which he gained some fame and much satisfaction. He held strong opinions on medical and other matters and his personality attracted many friends and some enemies. Snyder was unable to withstand what he termed "humbug" from doctors and other professional people, including ministers and priests. He was a deep philosophical thinker and a deist. His favorite philosophers included David Hume, Thomas Huxley, Benjamin Franklin, and Thomas Jefferson.

Snyder's love of politics continued from his early days. He had been elected to the Illinois State Legislature in 1878. Among the many causes he successfully promoted while a representative included the purchase of the personal library of the late Senator Sidney Breeze, which formed part of the foundation of what would become the Illinois State Library. He was one of the founders of this library and became one of its presidents. Snyder's interest in history impelled him to help establish the Illinois Historical Society and later to become its third president.

Outside interests included enthusiasm for studies in archeology, geology, history and natural history. Snyder achieved a certain degree of recognition and fame in these fields. He became an avid collector and created his own museum, the first in Illinois privately financed to house Indian and pre-Columbian artifacts. This museum, a separate building, was frequently open to the public. The extent of Snyder's preoccupation with prehistoric memorabilia is evidenced by his exhibit at the 1893 Columbian exhibition in Chicago.

Earlier in 1872, John had been elected a member of the American Association for the Advancement of Science. A long-standing member of the National Geographic Society and several natural history organizations, Snyder had numerous articles published. One such article of historical interest was titled "An

His correspondence leads the reader to conclude that John Snyder was dissatisfied in general that most medicines prescribed were more or less of an empirical nature and lacked the stamp of scientific logic in their use.



These three boxes, marked 1,2,3, contain perhaps eighty per cent of all letters I have received during my life*. Very few of them are of any historic value at present, but their historic value will increase with the passing of time. In donating them to the Illinois State Historical Society I particularly request that they be constantly kept in cases, or boxes, securely locked, subject, of course, to the inspection of students of Illinois history and biography, but not to be handled at pleasure by the general public merely to satisfy idle curiosity.

John F. Snyder.

* I have recently donated over 500 of my Missouri letters to the Missouri Historical Society at St. Louis.

Written verification in Snyder's handwriting of his bequest of correspondence to the Illinois State Historical Society. (Photo reprinted with permission of the Illinois State Historical Library.)



The Great Cahokia Mound near East St. Louis, which Snyder studied. Drawing is circa 1900. (Photo reprinted with permission of the Illinois State Historical Library.)

Outside interests included enthusiasm for studies in archeology, geology, history and natural history. Snyder achieved a certain degree of recognition and fame in these fields.

Illinois Burnt Offering," in which he related an incident in Cass County, near Middle Creek, where a religious fanatical group believing in human sacrifice burned a witch at the stake. (They were found guilty and fined three dollars each!)

Snyder also was the author of many important articles which are now used for contemporary research when no other evidence is available, particularly in the biographies of early politicians and doctors in Illinois. For instance, John Snyder was a contemporary and friend of Dr. Charles Chandler, the founder of Chandlerville, and Chandler's infamous son-in-law, Dr. Charles Lippincott—whose illustrious careers have been printed in this journal. He wrote a detailed biography of his great-grandfather Jean-Baptiste Saucier in 1901, and of his father Adam W. Snyder, a prominent early Illinois politician.

John Francis Snyder continued his active and diverse career throughout his life. His wife, Anne Lisa, died on January 7, 1918, and John died three years later on April 30, 1921, at the age of 91. The parents were survived by their four children, Frederick (1855-1937), Adele (1857-1943), Nellie (1859-1920), and Mary (1854-1952).

Snyder left behind an illustrious career as a physician, scholar, lawyer and politician. Few doctors in pioneer Illinois have had that distinction, and few men have received the accolades of so many colleagues as did Dr. John Snyder. ◀

Acknowledgement

This paper was funded in part by a grant from research funds of the Department of Medical Humanities, Southern Illinois University School of Medicine, Springfield.

EDITOR'S NOTE: The story of Charles Ellet Lippincott was previously published in *IMJ* (Pearson, E.F.: "A Country Doctor of Adventuresome Spirit," Vol. 170, No. 2, 1986.) Dr. Chandler was essayed in *IMJ* (Pearson, E.F.: "Dr. Charles Chandler of Chandlerville," Vol. 172, No. 5, 1987.)

Emmet F. Pearson, M.D., is a clinical professor emeritus of medical history in the department of medical humanities at Southern Illinois University School of Medicine. Dr. Pearson is promoter of the Pearson Museum of Medical History in Springfield. A past president of the Illinois Heart Association and past chairman of the Archives Committee of the Illinois State Medical Society, he is affiliated with Memorial Medical Center, Springfield, specializing in internal medicine.

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1988 AAMA Convention

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By Ehlma Garcia Mendez, CMA, EMT-A

The 1988 American Association of Medical Assistants Convention was held at the Marriott-Richmond Hotel in Richmond, Virginia, from Monday, September 26 through Saturday, October 1.

This convention was the first held since 1985. The Board of Trustees met the first two days and covered many issues. In addition, a leadership seminar was conducted by Mike Rippey for state presidents and presidents elect on Tuesday. Immediately following the House of Delegates business on Wednesday and Thursday, the inauguration of new officers took place, followed by an awards luncheon.

To assist the medical assistant in keeping abreast of the ever-changing and expanding health care field, a variety of educational sessions were offered at the convention. Clinical education topics included: Infection Control in the Physician's Office and The Physician's Office Laboratory. Administrative topics discussed were: Computers in the Medical Office, ICD-9 Coding, and Medical Office Financial Planning. A general session sponsored by the Certifying Board, was held Friday, which honored all Certified Medical Assistants.

The Illinois Society of Medical Assistants was represented by delegates: Robin Bluestein, CMA-C, president, Jean Fouts, LPN, president elect and Dolores Dupree, CMA. Alternate delegates were Charlotte Rubley, RN, CMA, and Mary Frances Burton.

For further information regarding the National Convention or ISMA contact Robin Bluestein, CMA-C, president, 10471 Dearlove Rd. #1B, Glenview 60025; Ehlma Garcia Mendez, CMA, EMT-A, public relations chairman, 5015 Briartree Ln #311, Burbank 60459; or Lucille Perce, CMA-C 22 W. 384 Teakwood Dr., Glen Ellyn 60137. ◂



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(continued from page 274)

by physicians of the same specialty as the physician under review for cases referred for utilization review issues.

TASK FORCE ON FINANCIAL AID TO MEDICAL STUDENTS

This is the sixth year for this Task Force activity, which granted loans for those years of 50, 75, 100, 125 and 175 thousand dollars. The total distribution of loan funds amounts to over $394,000. To date, five loans have come due and none are in default. The Board authorized that: $270,000 be released from the Illinois State Medical Society Student Loan Fund account for the purpose of providing student loans to eight Illinois medical schools for academic year 1988-89 in the following increments (with concurrent approval by the Educational and Scientific Foundation): Southern Illinois University, $15,570; Rush University, $35,610; Loyola University, $32,400; Chicago Medical School, $49,230; University of Illinois, $50,730; Chicago College of Osteopathic Medicine, $26,880; Pritzker School of Medicine, $37,980; Northwestern University, $21,600.

COMMITTEE ON DRUGS AND THERAPEUTICS

The Board approved the following drug products for inclusion in the IDPA Drug Manual: Prozac (Fluoxentine HCL); Pediapred (Prednisolone Sodium Phosphate); Estrace (Estradiol); Ogen (Estropipate); Novolin Pen ("Auto Injector" Insulin); Novolin Insulin Cartridges.

The Board also recommended that the following drugs not be included in the IDPA Drug Manual: Various unit dosages of Isoproterenol, Isoetharine HCL Metaproternol Sulfate, Cal Carb, and Anexsia 7.5.

In addition, the Board recommended the deletion of Duoderm from the Department's Drug Manual. Further, the Board recommends that Duoderm and all other like wound dressing products be added to the Department's Supply Program Manual for pharmacy billing purposes.

OTHER ACTIONS

In addressing various other issues, the Board:

- Accepted the: June 30, 1988, Financial Statements; August 22, 1988, IMPAC Collection Data; August 22, 1988, Dues Payment Report; and adopted Requests for Changes in Membership Status.
- Approved policy statements for inclusion in the Policy Manual. (Language will be reflected in the 1989 Policy Manual).
- Agreed to change the title of Secretary of the delegation to Vice Chairman.
- Referred consideration of mechanisms by which a reduction in delegation expenditures could be achieved to the Finance Committee, and agreed that no changes would be made in the current policy before the end of the current calendar year.
- Agreed to review the ISMS sponsored travel programs and research alternatives.
- Endorsed in principle the concept of IDPA cosponsorship with a medical school of a CME course to improve basic medical knowledge. This course will focus on basic techniques of office practice, including diagnosis, record keeping, physical examination, basic pharmacology, etc. A final proposal will be brought back to the Board for its approval.
- Agreed to cooperate with a proposed IDPA newsletter via involvement of the Society in reviewing and commenting on items proposed for inclusion in the IDPA newsletter which would cover topics related to Medical Quality Review Committee.
- Authorized the chairman to send a letter to the AMA objecting to the Health Care Financing Administration's recent activity which will now require the physician to advise the beneficiary of the particular reason why the service will be denied, and supporting the need for continued vigorous AMA response to the "Medical Necessity" issue.
- Approved introduction of a resolution amending the ISMS Bylaws, Chapter VI. Duties of Officers. Section 3. Vice Presidents, to allow appointment to fill a vacancy.
- Agreed that the *Illinois Medicine* member subscription rate be established at $6, which is included in the 1989 dues payment; and that non-member subscription rate be established at $12 for 1989.
- Approved *Illinois Medicine* Advertising Guidelines.
- Approved the ISMS CME Mission Statement and Goals which is required for continued accreditation as a CME sponsor.
- Approved legislative positions delineated in a primary list of House and Senate bills of interest to ISMS.
- Agreed to submit an Unfinished Business Report to the 1989 House of Delegates, recommending Resolution 21 (A-88), "Medical Staff Bylaws for Outpatient Surgi-Centers," not be adopted.
- Approved a seminar for young physicians and residents for Saturday, October 15, 1988, to include programming on topics of interest to young physicians. Faculty will be ISMS physicians and/or staff. Costs of this program would be approximately $3,800 (assuming 50 registrants), which includes

promotional and registration mailings, handout materials, meeting room and food and beverage costs, and other meeting costs associated with the seminar. This is covered in the current membership budget.

- Approved, in concept, the emphasis on student and resident recruitment and retention, along with academic recruitment in 1989, to include student, resident, and academic recruitment events, such as seminars, programs and receptions. Specific recommendations and programs are to be identified at the November meeting.
- (1) Authorized the co-signing of an upcoming Beautiful Babies mailing; (2) Agreed to continue to publicize the Beautiful Babies project; and (3) Agreed that, if necessary, ISMS send a letter to appropriate ISMS members encouraging participation in the Beautiful Babies campaign, at a cost not to exceed $2,000.
- Agreed to translate the ISMS brochure, "You Can't Be Too Careful: Facts for Teens (And Their Parents) About AIDS," from English into Spanish.
- Agreed that the Task Force on Financial Aid to Medical Students be made a permanent committee, composed of trustees, student and resident representatives and other consultants, as appropriate.
- Accepted resignation of Dr. Jerry M. Ingalls, Paris, ISMIS Director, and elected Dr. Ronald G. Welch, Belleville, to fill this vacancy.

PROGRAMS

The Board accepted the All Member Conference agenda and programs for Saturday, November 5, 1988, at the Renaissance Hotel, Springfield.

NOMINATIONS AND APPOINTMENTS

Various nominations and appointments were approved or ratified by the Board as follows:

- Dr. Cynthia Fraed, Harrisburg, Ninth District, as chairman of the Maternal Welfare Committee.
- Dr. Thomas Krizek, Chicago, to the ISMS Physician Assistance Committee.
- Dr. Phillip Boren, as consultant to the Council on Economics.
- Dr. Darrell Rust, Bloomington, nominated to serve on the IDPH Emergency Medical Services Council.
- Drs. Allan Bennett, Carbondale, and Edward Klink, Rockford, nominated to serve on the IDPH Family Planning Advisory Council.
- Drs. Gary Silverman, Northbrook, and Michael F. Cristoforo, Rockford, nominated to serve on the IDPH Ambulatory Surgical Treatment Center Advisory Board.
- Dr. Edward J. Fesco, to serve as Liaison to the Illinois Society of Medical Assistants.
- Dr. Charles L. Swarts, to serve on the Illinois Interagency Council on Smoking and Disease.
- Dr. Peter E. Friedell, to serve on the Illinois Cancer Council.
- Dr. Vincent A. Costanzo, Jr., to serve as Delegate; and Joseph H. Skom, as Alternate, to the U.S. Pharmacopaeia.
- Agreed to endorse K. Gregory Lucchesi's candidacy for the student position on the AMA Board of Trustees.

MEETING WITH GOVERNOR

Officers and staff met with Governor Thompson and Deputy to the Governor James Reilly. The Governor recommitted himself to working with the Society towards the passage of limitations on noneconomic losses. He did, however comment on the difficulty in passing such a measure with the current legislature. He was advised that the Society would be assessing this situation after the November elections.

Governor Thompson listened with interest to the Society's arguments in regard to House Bill 4005, the legislation providing an exemption from written informed consent upon a physician's order for an HIV test. The Society will continue to work with the Governor on these and other issues of interest to the Society.

SPECIAL GUESTS

The Board heard reports from Dr. John J. Ring, Chairman, AMA Board of Trustees; Dr. Lawrence L. Hirsch, Chairman, Medical Licensing Board; and Dr. Irene Caruso, Chairman, Medical Disciplinary Board.

INFORMATIONAL REPORTS

The AMA Delegation chairman agreed to consider the expenses of the delegation when it was referred by the Executive Committee and Finance Committee.

Informational reports were presented by the Council on Medical Services, Committee on CME Accreditation, ISMIS, ISMIE, Resident Physicians Section, Auxiliary, IMPAC, Trustees and Speaker.

NEXT MEETING

The next Board meeting was set for November 4, 1988, at the Renaissance Hotel, Springfield. ◀

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STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Required by 39 U.S.C. 3685)

1A. Title of Publication	1B. PUBLICATION NO.	2. Date of Filing
IMJ - ILLINOIS MEDICAL JOURNAL	2 5 8 1 6 0 0 0	September 29, 1988
3. Frequency of Issue	**3A. No. of Issues Published Annually**	**3B. Annual Subscription Price**
Monthly	12	$12.00

4. Complete Mailing Address of Known Office of Publication (Street, City, County, State and ZIP+4 Code) (Not printers)

Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602

5. Complete Mailing Address of the Headquarters of General Business Offices of the Publisher (Not printer)

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6. Full Names and Complete Mailing Address of Publisher, Editor, and Managing Editor (This item MUST NOT be blank)

Publisher (Name and Complete Mailing Address)

Illinois State Medical Society
Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602

Editor (Name and Complete Mailing Address)

None

Managing Editor (Name and Complete Mailing Address)

Mariann M. Stephens, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Item must be completed.)

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10. Extent and Nature of Circulation (See instructions on reverse side)	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
A. Total No. Copies (Net Press Run)	19,200	19,207
B. Paid and/or Requested Circulation 1. Sales through dealers and carriers, street vendors and counter sales	-----	-----
2. Mail Subscription (Paid and/or requested)	12,768	12,722
C. Total Paid and/or Requested Circulation (Sum of 10B1 and 10B2)	12,768	12,722
D. Free Distribution by Mail, Carrier or Other Means Samples, Complimentary, and Other Free Copies	5,878	5,889
E. Total Distribution (Sum of C and D)	18,646	18,611
F. Copies Not Distributed 1. Office use, left over, unaccounted, spoiled after printing	554	596
2. Return from News Agents	-----	-----
G. TOTAL (Sum of E, F1 and 2—should equal net press run shown in A)	19,200	19,207

11. I certify that the statements made by me above are correct and complete

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Medical Disciplinary Orders

- *Rifat Erenmemis* (lic. # 036-043682 & 003-036-043682)
 Effective August 23, 1988, Dr. Erenmemis' medical license was suspended for one year, retroactive from July 24, 1987, and his license was then placed on a two year probation, commencing on July 25, 1988.
- *Miguel Nayan* (lic. # 036-063959)
 Effective August 30, 1988, Dr. Nayan's medical license was suspended for a period of four months and will be placed on probation for two years after the suspension. He was also fined.
- *David P. Richerson* (lic. # 003-036-032208 & 036-032208)
 Effective September 2, 1988, Dr. Richerson's medical license was placed on probation for three years, and his controlled substance license was suspended indefinitely.

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YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

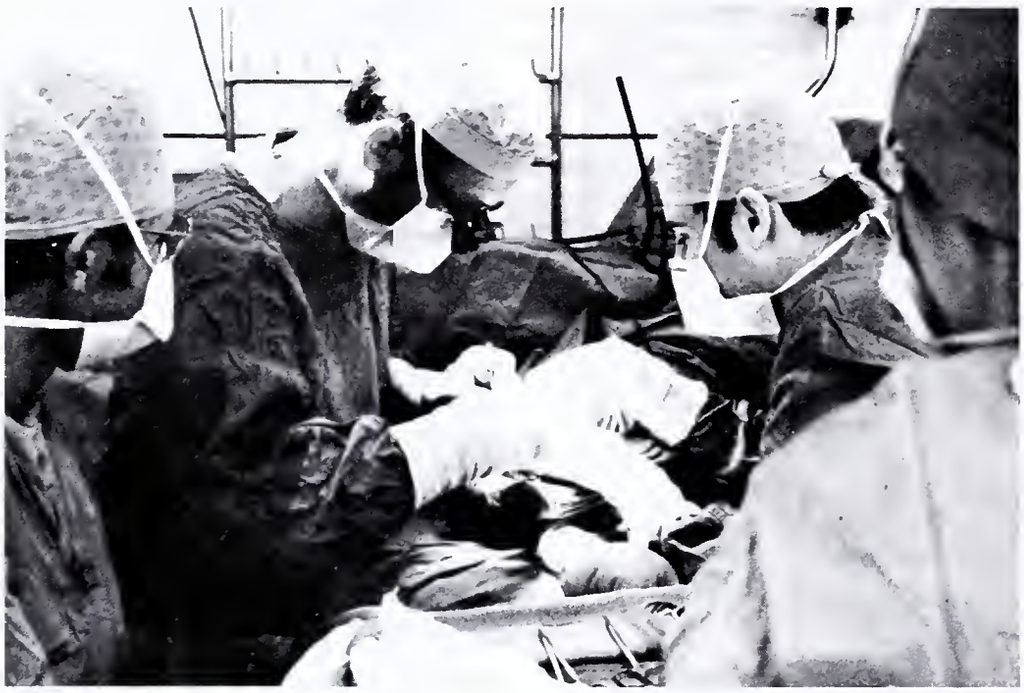
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FAMILY PRACTICE—FOR SALE. Small town—NW Indiana. High income. Hospital in town. OB/ER/optional. Hospital may assist financially. Chicago 90 minutes. South Bend 60 minutes. Reply: PO Box 93, Valparaiso, IN 46384.

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Exchange Insights

November, 1988

ON MALPRACTICE PREVENTION

The Board of Governors of the Illinois State Medical Inter-Insurance Exchange presents "Exchange Insights on Malpractice Prevention" as a service to Illinois State Medical Society members and Exchange policyholders. This monthly feature is designed to educate physicians on those areas in their practice which have the potential for causing claims, and to offer possible ways to minimize risks. **Exchange Insights** *may be removed and kept with your other important Exchange professional liability information.*

How Your Staff Can Prevent Malpractice Claims

Your office environment, procedures, and staff conduct all contribute to the way your patients evaluate you. It is crucial, therefore, for physicians to critically review the manner in which their office operates in order to identify and correct areas of potential patient dissatisfaction.

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Patients often sue because they are angry and feel alienated from their physician and the health care team. One of the most common causes for patient dissatisfaction stems from inadequate communication.

Patient communication is a team effort; it is the responsibility of everyone in the office who has contact with the public. And it begins where the patient relationship does: when the patient walks in the door or telephones your office. It is here that the tone of your relationship is established. Afterall, you never have a second opportunity to make a first impression.

The ill or anxious patient who visits the office or calls to make an appointment deserves to be treated with understanding and professionalism. A prompt, pleasant, courteous and helpful response is essential. When the staff's problems cause them to forget that patients take top priority, the rapport you have established, or will establish, may be jeopardized.

Also, what message does your waiting room convey? Consider the physical layout, cleanliness and overall feel of the room. Instead of being cold and forbidding, waiting rooms should be warm and comfortable, welcoming the patient. Even the magazines have significance. It is difficult to convey the impression that you are up-to-date medically if the periodicals are two years old. You'd be surprised to learn the assumptions patients make about your medical competency based on "non-medical" aspects of your practice, such as your waiting room's appearance. . . or the amount of time patients spend in it waiting to see you.

The world's champion builder of ill-will among patients is an excess of what the room is for: waiting. Chronic waiting room delay is a contributing factor behind patient antagonism toward the doctor, predisposing patients to file a lawsuit.

The problem is not the waiting itself, but the implicit attitude behind it. Some patients report the feeling that they've been treated with indifference—that, presumably, they are not important enough to deserve prompt attention.

To minimize waiting time, review your appointment scheduling procedures periodically; they may be ineffective. Ask your staff to keep an informal log to see how long the average patient now waits to see you, both in the waiting room and the examining room. For example, over a period of two weeks, log every fourth or fifth patient, recording the times of their appointment, arrival, meeting with the doctor and departure.

In addition to indicating average wait time, the procedure may help you improve your scheduling patterns by revealing times of the day or week that are typically more or less busy.

Also, if you are running behind, make sure your receptionist informs your patients, and tells them why. When possible, patients should be offered the option to reschedule rather than wait. If they do choose to come back another time, have the receptionist put a note in the appointment book that cautions against keeping that patient waiting a second time. And whenever there are delays, make certain that all who serve the patient express their apologies.

Protecting Confidentiality

Most people are anxious that information about them not be disclosed to others without their consent. This is particularly true in the doctor's office where the information about them can be extremely personal.

Staff can protect a patient's privacy by not discussing his medical treatment in the presence of other patients.

Keeping the window to the waiting room closed while talking on the phone reduces the risk of inadvertent disclosures. Careless conversation gives an unprofessional impression and can result in a costly and difficult-to-defend invasion of privacy lawsuit.

Also, information about a patient should never be given over the phone unless the caller's identity has been verified and his access to the data has been authorized by the patient. In addition, medical records should never be released without the patient's written authorization. It's a good idea to establish and enforce office policy concerning the release of health data. Unauthorized release of information will not only damage patient rapport, but may also leave you open to a lawsuit.

Office Procedures

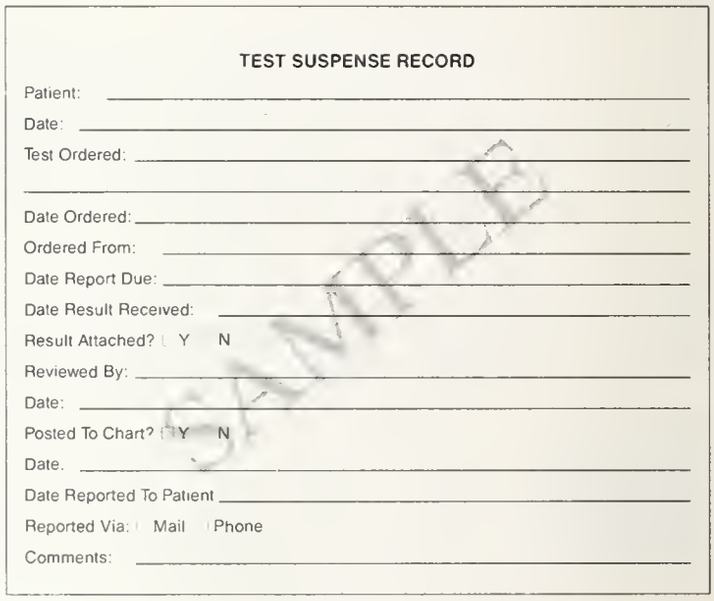
Billing and Collection: There are few better ways to provoke a lawsuit than to send overdue and dunning notices to an already dissatisfied patient. On the other hand, you do have every right to expect payment, and forgiving a legitimate charge may even be interpreted as tacit admission that the treatment was not up to your normal standards. Clearly, then, billing and collection issues can present you with difficult decisions.

Rather than adopting hard and fast policies, it is probably better to treat each case individually. Whether or not you make an adjustment is a matter of judgment. But it is a matter of necessity that you take the time to make that judgment yourself, and not delegate it to staff. Establish a procedure in which your staff automatically refers to you all instances of fee dispute so that you can personally review each bill about which there is a complaint, as well as those that are scheduled to be sent out for collection. Your intervention in the billing process can help to resolve patients' problems, thereby averting a lawsuit.

Patient Complaints: Also ask your staff to report to you any patients who voice complaints to them. Patients are sometimes reluctant to express their dissatisfaction to you, but often vent their feelings to a staff member on the phone or as they are leaving your office. The patient whose concerns are ignored may consider legal action to get your attention. Therefore, it is important to encourage your staff to inform you of any patient complaints so that you can contact the patient, address his concerns, and prevent a lawsuit.

Test Results: One common basis for litigation is the "missing test"—the one that is ordered and then, at some point along the way, "disappears." Carelessness in tracking tests can cause dangerous delays in diagnosis or treatment. Therefore, it is imperative that every office have an airtight system for determining that each test ordered was: 1) actually performed; 2) reported to your office; 3) seen by you or a colleague; 4) reported to the patient; 5) acted upon; and 6) filed in the appropriate place.

Work with your staff to develop such a system. You might use a follow-up or suspense form (see example below) that requires written dates, initials to confirm that the test was ordered and performed, that the results were reported to the office and reviewed by you, that they were conveyed to the patient, and that they were properly filed.



TEST SUSPENSE RECORD

Patient: _____

Date: _____

Test Ordered: _____

Date Ordered: _____

Ordered From: _____

Date Report Due: _____

Date Result Received: _____

Result Attached? ☐ Y ☐ N

Reviewed By: _____

Date: _____

Posted To Chart? ☐ Y ☐ N

Date. _____

Date Reported To Patient _____

Reported Via: ☐ Mail ☐ Phone

Comments: _____

SAMPLE

Failed Appointments: When a patient misses an appointment, you should attempt to reschedule. This is important not only for good health care, but also to demonstrate that you have made a reasonable effort to contact the patient. If you do not, you may open yourself up to a claim for the consequences of failure to treat.

Each day, your receptionist should review the day's no-shows. The receptionist should attempt to reschedule them at a time consistent with the urgency of the case. Have your receptionist keep clear, specific records of both the missed appointments and the efforts to follow-up. If, after repeated attempts, the patient cannot be reached by phone, have your receptionist send a written letter to the patient requesting that the patient reschedule, and make sure your receptionist keeps a copy of it in the patient's file.

A Team Effort

In most cases, you will direct the policies and procedures described above, but generally, it will be others who carry them out. It is important that everyone in the office—all physicians and staff—have a consensus and a clear understanding regarding your management practices. Your policies can only be as effective as they are consistent.

Exchange Insights is not intended to provide legal advice, and no attempt is made to define conduct which would have been appropriate in particular cases to meet acceptable standards of care.

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TTEBANN M. NRNGEE, M.D.
10 Main Street
Anytown, U.S.A. 00000

Name _____ Age _____
Address _____ Date _____

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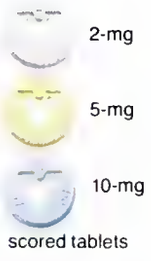
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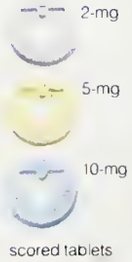
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